FLAACOS 2019 PANEL INPUT

=SUMMARY OF ACO EXHIBIT HALL ADVISORY BOARD RESPONSES=

November 8, 2019

On November 8, 2019 the Executive VP of the ACO ExhibitHall.com (ACOEH), John Schmitt, Ph.D., MBA, will participate as a panel member of the session titled "Mind Share is Market Share-Moving Your Panel to Value-Based Healthcare Models". He will be joined on the panel by Dr. Brent Staton, CEO of CCHI ACO, an ACOEH Advisory Board member as well as Tim Weldon, CDO, Canton and Company. In preparation for the session the Panel Moderator, Larry Jones, CEO, Independent Healthcare Partners, proposed the five questions below to be addressed by the panelists.

Realizing the valuable resource available within the ACOEH Advisory Board (AB) membership, Dr. Schmitt invited all AB members to provide their input to one or all of the panel's questions. In turn, he offered to send all respondents a summary of the collective responses for their information. Responses to each question are not identified with specific contributors.

Below are the five panel questions and the responses received from the AB member respondents:

1. **<u>Experts say value-based care will continue to become more prominent in contracts, so what strategy do physicians need to adopt in contracting and participating in outcomes-based relationships?</u>**

Respondent 1:

Clinical quality will continue to be prominent in value-based contracts. It will become increasingly important to have similar measures (hopefully to most meaningful and impactful) across contracts, and specific to key drivers of health regionally, so that physicians can target efforts across populations. We can no longer ask physicians to "chase lists" of patients with quality gaps defined by payors. We need to work toward redesigning care to achieve high quality outcomes across all populations. This requires aligning clinical quality measures and incentives across populations.

There must be flexibility in contracts to account for regional variation in outcomes. Also, the thresholds to achieve the highest tier outcomes must be reasonably achievable. (If 100% quality performance can only be achieved if all patients with diabetes have an A1C < 7, then it will never be achieved). For clinical quality measures that include medication adherence, physicians need to advocate for benefit design that makes these medications easily available to patients ($0 co-pay for inhalers if asthma or COPD outcomes are quality measures).

For value-based contracts, the financial benchmark by which cost performance is measured is critical. Physicians need to understand benchmarking, how the models work, which factors are included. In general, there should be four basic factors in benchmark modeling: historical spend for the population, anticipated trend of cost increase, risk of the population,

and regional variation (or regional efficiency – meaning comparing systems and groups within a region to each other rather than just national comparisons). Understanding the nuance of these factors is important for physicians to begin to understand.

Value based contracts need to recognize and support the up-front investment needed in population management, care team development and other infrastructure needed to successfully manage populations. Highly organized and advanced physician groups can invest in these resources and be successful in risk-based contracts with high rates of shared savings. However, provider groups that are new to value will need a ramp and roadmap to successfully manage populations at risk e.g. care management pharmacy interventions, data and analytics to identify opportunities to reduce unnecessary cost and reduction of unwarranted variation in care practices.

Physicians need to understand where cost is incurred in the system in which they practice. Primary Care Providers (PCPs) have significant impact on the total cost of care (TCOC). However, they account for only about 7% of TCOC themselves. For PCP's to effectively manage TCOC they need good data on specialty provider practice patterns and costs, hospital practice patterns and cost, and post-acute provider patterns and cost. This is difficult – and the data needs to cut across populations. Small denominators exacerbate variability. More data in denominators starts to show practice patterns, which are then actionable – if a cardiologist sees only 5 patients in a particular contract, and 1 is very high cost for very legitimate reasons, that provider's cost will show as high, and no patterns can be identified. If that same cardiologist sees 100 patients across value contracts, then real care patterns can start to emerge.

Physicians need to be willing to work together, coordinate, share information and data and collectively determine best practice standards that meet patients' needs considering geographic influences on health outcomes. For example, physicians in a particular region can agree on the best care for patients with COPD, who often are a key driver of cost. This may mean agreeing to see patients within 5 days of hospital discharge, or agreeing on best treatment protocols. For contracting, physicians can champion the need for payors and providers to co-invest in transportation solutions, integrated behavioral health programs, food sources for patients who are food insecure etc.

Respondent 2:

The days of PCPs referring to a Specialists and not knowing the outcomes needs to end. When a Specialist receives a referral and does not follow up with a PCP-that should never happen. Breaking down practice silos and communicating effectively does not need to be complicated. Solving this problem is crucial if a physician Network is to participate in outcomes-based relationships.

Respondent 3:

Physicians should understand that value-based care (VBC) is going to represent a material % of their revenue by 2025 in most states making it very important to build infrastructure to succeed in these types of arrangements, or align with an organization, such as a CIN, that offers population health tools and contracting opportunities. A worst-case scenario would be a small independent physician group being caught by surprise by being involuntarily

placed into a downside risk value-based arrangement with no infrastructure to succeed. Interestingly, the entire Medicare program is now a value-based contract with downside risk, so to some extent this is already happening.

Critical infrastructure includes: population health management IT systems to document quality, coding and utilization processes, provider education and engagement regarding VBC KPIs, and investment in new clinical resources including care management personnel.

Respondent 4:

Physicians need to work on making and documenting quality improvements before engaging in contracting with insurers or MSSPs. Engaging in the basics of the MIPS program will help physicians learn how to better manage an attributed population.

Respondent 5:

Medicare Advantage (MA) Plans have been reluctant to delegate risk management control to providers. Rather they are internalizing or building up their own health management and access infrastructure. In part, physicians are to blame for not embracing value-based care (VBC) earlier which frustrated carriers. Many big provider systems already have their own products (commercial and MA). Physician sponsored VBC organizations will need to do the same while internalizing their own management capabilities. Payer lines are blurring and it's a race to gain captive lives and reduce the opportunity for insurance plans to leverage their market share. Meanwhile, physician VBC plans are trying to construct meaningful incentives as a portion of the administrative PMPM. Overall, physicians have a distinct advantage to market their VBC plans to their own patient base.

Respondent 6:

The core strategy physicians need to adopt in value-based contracting is a change in culture. Physicians are scientists who have historically practiced in treatment silos. Physicians now need to change how they view themselves and their role in patient care. The change was expressed in a recent article in Population Health News as a move from the "soloist model" to an "orchestral model". In other words, physicians need to envision themselves as collaborators in a patient care team and leverage the talents of providers serving within the complete care continuum to jointly achieve quality of care at a reduced cost. The best way to achieve this culture change is to find "physician champions" of team care culture. Then give them the time and resources needed to lead the new change in thinking among their physician colleagues.

Respondent 7:

In order for physicians to succeed in evolving payment models where they are at financial risk for patient outcomes, the most important strategy will be how to align with a capital partner that supports the physicians' vision. According to NAACOs, the average cost of building a single ACO is around $2M – an amount of capital that physicians often lack. Since physicians typically organize into professional corporations and dividend out earnings to the greatest extent possible, capital reserves are typically intended to cover overhead and not necessarily expand or assume risk. The payment structure is going to change, causing healthcare to be organized and structured differently—and all of

that points to consolidation. Physicians have a unique opportunity to consolidate with other peers to form a larger provider infrastructure or to work within a health system setting.

For outcomes-based care, results point to physician-led ACOs being at an advantage because they're more agile and they're un-conflicted. Hospital-led ACOs must contend with demand destruction on their fee-for-service lines of business if they reduce admissions, emergency department visits, and procedures. A majority of savings elicited comes from keeping patients out of their doors, making the hospital bear the loss. This motivates hospital-led ACOs to focus on getting revenue through seeing more patients and preventing leakage from the system. Physician-led ACOs simply do not have this dichotomy; therefore, they have a clearer pathway to financial benefits from reducing hospital costs outside of the physician practice. With a capital partner that can support physician independence, physician-led ACOs should be able to prosper in the long-term.

2. **<u>What is the formula within a physician practice to better engage their patients in outcomes-based care?</u>**

Respondent 1:

Patient activation is the formula: Ed Wagner's Chronic Care Model outlines the need for Activated Patients to engage with proactive, prepared care teams in order to improve outcomes for chronic disease. An activated patient has three things: education about the disease process, tools for them to improve their own care, and motivation to use the education and tools. Easy to say, hard to do. Motivation can often mean better managing anxiety, depression or other affective disorders. It may also mean reducing stress about having to make a decision between the electric bill and needed medications. Increased patient activation leads to better clinical outcomes.

There is significant discussion about price transparency and how that will drive patient choice of higher value care. That hasn't borne out in research based on robust data. Patients do make decisions based on co-pays and out of pocket expenses – increase the co-pay for an ED visit from $50 to $300 and you see fewer ED visits for example. I do think that price transparency to physicians can help drive value- based decision making. If a physician participated in a value-based contract, and knew the cost of an MRI at three different centers as well as the outcomes at those centers, they would likely choose the highest value center to refer to. The same holds for many other services (dermatopathology is another good example). Patients will most likely go where their physician recommends that they go. They trust the physician as their primary care provider and that he/she is making decisions in their best interest.

Shared decision making: lots of research on this. The process of preventive care and screening is where this comes into play most. A good example is colorectal cancer screening – 3 modalities to use for screening, highly variable cost, similar outcomes.

End of life care: In the 8th decade of life, US healthcare costs 4-5x than any other OECD country. Patients want physicians to talk to them about end of life care, palliative care and hospice. However, physicians don't tend to do it. However, they need to, and they need the resources to do it well. We would significantly affect the cost of care, improve patients'

experience of care and most likely help patients live the end of their life according to their real wishes if we developed robust, routine processes to discuss end of life care.

Respondent 2:

Achieving patient engagement is the Holy Grail of fee for service medicine, isn't it? How do we engage patients that have complete freedom of choice? This starts with the Annual Wellness Visit (AWV) which must be taken as seriously as a heart attack (pun intended). The entire practice must understand the AWV as, not only a baseline and roadmap for the patient's coming care, but as a means to engage the patient in a verbal "contract" regarding their responsibility in that care.

Whether it is smoking cessation, diet or medication adherence, the patient must agree to realistic small goals for the coming year and the AWV should be referenced in subsequent visits. I've always believed a score card would be an ideal EMR tool that might be provided to patients with each visit- it works for Jenny Craig and most personal trainers.

The practice absolutely must examine it's structure in a brutally honest way. Does it operate as a Physician Sovereign organization, with all staff actions aimed at supporting the physician's progress note? If so, that is one very overworked and inefficient physician and one very overworked and soon to be burned out, robotic staff.

Medical Assistants (MAs) did not sign on to simply do height, weight, BP and phone in a referral or prescription. They want to be involved in actual patient care and should be encouraged to work to the highest level of their training and ability. They can be essential in the AWV process, completing falls screening, depression screening and much more. They can be cross trained as certified coders and prep physician charts to make certain stale diagnoses are addressed and care gaps are filled. The physician who fails to realize his/her MA's capabilities will find patients often confide more in the MA than the physician thereby doing his/her practice a real disservice.

Further, the Office Manager should be far more than a billing and employee supervisor. He/she needs to be capable of providing summary reports regarding patient panels, care gaps and quality metrics. The manager should be charged with fostering a culture that encourages all employees to think of the patient as a voluntary client, rather than a medical burden or source of work.

Finally, practices should find ways to team up with colleague practices to provide essential services like pharmacists and behavioral health. Very few primary care practices can afford a social worker; but a group of three or four like-minded practices might…especially if they're billing for CCM and keeping an eye on new Medicare payment codes for such services.

Respondent 3:

PCP's need to be willing to encourage patient engagement and also learn motivational interviewing skills when discussing chronic conditions. What I mean by this is setting realistic goals but also stretching those goals so that the patient must track and provide

updates at visits. If patients do not have interests in this, then the physician should be able to provide the name of another PCP that can simply provide 'sick care.'

Respondent 4:

Providers have to be given information to better engage patients across three critical domains: quality (gap in care closure), utilization management and coding. To do so, providers need systems that inform them of which patients need the most attention, and which messages to convey. For example, an ideal point-of-care, Population Health Management (PHM) system would allow for:

- **Identification of high-risk beneficiaries (at high risk for a future high cost utilization event or disease exacerbation) and if the beneficiary is in a value-based contract;**
- **Information on any contract-based gaps in care the beneficiary is indicated for but has not received (e.g. mammogram);**
- **Details regarding any recent high-cost utilization: who, what, where, why (e.g. ED visits that weren't admitted for UTI);**
- **Coding opportunities to improve future VBC benchmarks: for Medicare contracts, HCC tools.**

All this allows providers at the point of care to efficiently act on actionable information while the patient is in front of them. I should note that there aren't many products out there that can do all of these things, but we're getting there. Systems we're evaluating also include a Health Information Exchange (HIE) component to create a true community medical record to share clinical values at the point of care from multiple EMRs.

Respondent 5:

Implementing a program of annual wellness visits is essential so that patients become better attached to the practice.

Respondent 6:

Until CMS relaxes the rules, ACOs have limited opportunity to induce patient motivation and compliance. Its hard work to motivate the percentage of patients who delay until they crash or think they know best when it comes to their own health. Physicians must get better at messaging the long- term impact of care and communicate to patients the predictive outcome of nominal engagement. Interventional care teams also can support the provider's dialogue in simplistic terms that give the patient an understanding of their condition. Practice staff must be available, promote the call center, and distribute applicable material. Consider using home health as another support mechanism for patient education and long-term care planning to manage comorbid taxing cohorts. I look for CMS to continue to give ACOs more opportunity to promote wellness.

Respondent 7:

A critical element of achieving patient engagement is the elimination of obstacles preventing ill patients from getting the supportive resources they need for their care. Research shows that only 25% of hospitals and 15.6% of physician practices currently screen patients for five social determinants of health (SDoH): transportation needs, interpersonal violence, housing instability, utility needs and food insecurity.

The more progressive health systems, like Spectrum Health in MI, have redefined their mission "from a sickness model to a wellness and a health model". Spectrum's CEO reports the system has made a significant investment in SDoH screening and is actively partnering with community organizations to provide resources to meet their patients' needs. Another system reporting SDoH success in Modern Healthcare (9/16/19) is Marshfield (Wis) Clinic Health System. The system attributes the program with "helping reduce the cost of care by 17% to 30% and readmissions are down 44%".

Respondent 8:

A physician practice can better engage patients in outcomes-based care by dispersing leadership within the clinical environment. By deconstructing the traditional approach to delivering care by decentralizing power, creating more interconnectedness within a multidisciplinary care team, and allowing all care team members to practice to the fullest extent of their license, providers can better organize around this new idea of value-based care. Since physician-led ACOs are by default more effective in garnering buy-in from physicians, they are likely going to be more successful at doing things like reducing imaging, providing urgent care on weekends, increasing medication compliance, etc. I think patients may also potentially be more engaged in these models as well, especially if care is being provided through a patient-centered medical home.

Lastly, I think patients will become more engaged when providers are able to do a better job of addressing social determinants of health. In healthcare, we are overdue for a "Moneyball" revolution. The shift towards value-based payment has made it clear that our system needs to do a better job generating outcomes that matter to patients — a positive health-care experience, improved health, and good quality of life. Many of our conventions in delivering care come from an era when healthcare was delivered primarily by doctors and nurses with elite training whose success depended mostly on content expertise. This paradigm is outdated; we now know that social, behavioral and relational factors — like social support, lifestyle, diet and even a patient's relationship with her healthcare team — are critical drivers of health.

3. **<u>What do you think Commercial, Medicare Advantage, and Medicaid payers want from providers when evaluating a value-based agreement?</u>**

Respondent 1;

Payors want providers to increasing accept the downside risk for the total cost of the patient in exchange for the sharing in any value delivered to the patients. That challenge is to ensure that the risk is proportional to the gain. In the Medicare Advantage (MA) space, payors want to have either a PCP or total capitated model. With the correct infrastructure

and agreement in place, such models can be of high value to the PCP practices. Additionally, payers want to see the quality improved in alignment with the HEDIS measures they are held accountable for currently. They increasingly want to fully validate and understand the infrastructure and processes providers have implemented in their traditional office practices to ensure higher levels of patient population management.

Respondent 2:

The first thing we need to do here is realize the distinction between primary care and specialists. Both groups should start with the way they approach the basic practice of medicine. It is no longer about treating complaints (CPT Codes). It's about treating conditions (ICD-10 diagnoses). This may seem simplistic, but mindset is often overlooked. Quite often, physicians see no difference between population health and the episodic care they've been trained to provide.

The primary tool in population health is the EMR. The EMR is no longer a simple recording tool. It needs to be geared toward population health and should provide:
- Alerts for gaps in care and diagnoses that have not been addressed
- Clean and customizable templates for various diagnoses and processes/procedures
- Ability to create patient panels and report, on a summary basis, key measures of performance
- Ability to perform, document and report CCM and TCM codes

For the primary care physician, alignment with like-minded professionals is essential, since all pay-for-performance initiatives start with a minimum number of requirements, which no single practice will be likely to meet.
- Is the group/organization able to provide ongoing training and reports regarding coding performance, comparative expenses, patient risk stratification and predictive analysis?
- Does the group/organization have a process in place to identify and address post-acute and transitional care needs?
- Is the group selective about the providers it takes on, or is it seeking size for size?

Respondent 3:

Commercial payers: Commitment to high quality outcomes, to redesigning care to reduce total cost of care and rate concessions to reduce premiums.

MA payers: Commitment to very high patient experiences. The MA model is built on patient retention – if patients stay in the product, with high HCC scores and close quality gaps the payers need much fewer resources the following year (and therefore lower MLR and more profit from MA plans). MA payers also want providers to engage in appropriate HCC coding.

Medicaid – If managed Medicaid, then similar to both above, with a provider commitment to focus on maternity care, social determinants of health etc. If not managed Medicaid, then more likely Medicaid wants providers to engage with community agencies also working with Medicaid patients.

Key point: MA plans (and now many commercial plans) are no longer willing to wait for providers to change. They are actively investing in care delivery themselves, examples include: Aetna/CVS, Humana/Kindred, United/Optum/Davita etc. Humana has stated

publicly that they want half of their workforce to be clinical providers within the next few years. MA plans are contracting with Landmark, Iora, CityBlock, Caremore, etc to manage highly complex Medicare patients to ensure high quality, high levels of patient experience and aggressive reduction of utilization resulting in reduced cost of care. Providers can no longer sit on the sidelines and watch or they will be quickly passed by.

Respondent 4:

Every contract we negotiate is a win-win, meaning both have objectives towards improved quality (achievable metrics), and improved costs (defined by the services provided - past utilization). However, part of the negotiation begins with a presentation from the ACO depicting how we have achieved this before. As a result, many times the Payers come with their reports and are unaware of our capabilities and many times their reports are inaccurate. This leads to why, in every contract, data exchange must be part of the agreement and the Network needs to have a trusted advisor to create actionable data.

Respondent 5:

Our state has become an aggressive VBC state. The payers want accountability from the providers. Accountability is translating into obligatory, multi-year glide paths to downside performance risk contracts across all business lines.

Respondent 6:

They want to see the practice is organized to produce high quality results, adequate staffing and expertise to execute the contract.

Respondent 7:

The number one thing payers want is the opportunity to scale growth with very little outlay of capital. If payers can enter a market with little to no penetration, they can rely on the internal promotion of the value-based care organization to migrate patients from their captive pool of patient lives. Those who already have significant penetration will need the ACO to yield cost savings demonstrated by prior savings history or administrative efficiency by reducing the duplication of services and streamlining connectivity to more complete medical records.

Respondent 8:

At the heart of the payer/provider relationship is mutual trust. The history of fee-for-service negotiations has left that relationship at a low trust level since the outcome was seen as a win-lose result. However, the success of value-based agreements requires payer/provider collaboration at a high trust level.

Stephen M. R. Covey, author of The Speed of Trust, maintains it is possible to build trust doing at least three things:

- **Be mutually transparent e.g. providers want timely, accurate claims data, payers want documented, reliable provider performance information;**
- **Make and keep commitments e.g. develop a mutual action plan for VBC agreement accomplishment with timeframes and keep to it;**

- **Be mutually respectful e. g. maintain a high level of integrity and openness in communications, data exchanges and collaborative risk management processes.**

Respondent 9:

Payers seem to be reluctant to delegate control to providers based on historical misunderstandings and early failures to adopt value-based care. As they are under pressure to collaborate in a more meaningful way to improve outcomes, I think they would want to see an early track record of results which demonstrates a commitment to population health management. The MSSP program, for example, could illustrate the propensity of a provider group to execute on the tenets of value-based care and improve outcomes within a challenging population. With early indications for success, coupled with a minimal capital outlay requirement, payers do seem to be warming up to innovative approaches to collaborating with providers. Clinical integration is also an important value proposition; however, meeting that standard of care could be challenging when aggregating multiple independent physician practices within a value network.

4. **<u>Data is a key component in managing patients, what is needed for providers to harness patient data and drive performance improvement?</u>**

Respondent 1:

At a minimum there should not be any relationship with a payor that transfers any risk if they are not willing to provide claims data on the members who are in the program. If this can be integrated with EMR data, then that is optimal, but the claims data is very rich from an information perspective when it can be quickly ingested and evaluated across key utilization measures. Additionally, I personally believe that providers must find a way to ensure that their EMR system can actually identify, differently than non-value-based members, the members that are in a value-based program through the use of a roster management engine.

Respondent 2:

Providers must have actionable data. They get overwhelmed with too much data or if it is not very specific, they cannot not do anything with it. Also, if they are given too much data, they simply do not look at it either. The data given to the providers has to be clear and concise. Actionable data should be data that has a particular one or two actions to achieve the goal. Physicians also need to have clear and concise instructions on what to do with the data as well. Giving physicians a list of patients that need to be seen frequently or patients who have not been seen in a certain time frame, etc. are data that physicians can manage and see movement with respect to their performance.

Respondent 3:

Cost of care: As providers, we know quality and how to measure it. We need to quickly move towards having good data on practice patterns, cost of those patterns, and data across populations. We need to have actionable data at the population level and at the point of care. If Sepsis is a key driver of cost, and you're an ambulatory provider, that's not useful. If your

panel of patients has high ED utilization rates – that's not enough. You need to know which patients, which conditions, how that relates to your practice – daytime access, nighttime coverage etc. Utilization rates alone are not actionable – which conditions, which patient populations and what the key drivers are is actionable and can lead to changes in practice design (access, better triage etc.), or better management of chronic disease.

High value referral patterns: which specialists are of the highest value as VBC providers? Payers must help get that data in front of PCP's. For hospitals – which conditions, procedures, etc. are outliers in terms of cost compared to similar institutions (total cost of care, not operating costs). Focus on those.

In general, data needs to be timely, actionable, and relevant across populations and not payer specific (docs can't provide different care for different populations based on payor relationships). Data needs to be aligned with the intrinsic motivation that physicians have to improve their patient's health, aligned with their financial incentives, and actionable for care teams, not just physicians. As a good friend and colleague says – if all we are doing in value-based care is putting more "chase lists" in front of doctors to chase patients with "x" or "y" situations or chasing patients with high utilization patterns …. We will lose.

Respondent 4:

Provider organizations need analytic capabilities to ingest claims, A/D/T and clinical data inputs to provide risk stratification and predictive information to care managers. Data is needed to analyze population-level trends to identify opportunities for improvement.

Respondent 5:

Providers need an excellent EHR system that provides the ability to manage the attributed population.

Respondent 6:

Historical data allows providers to test and modify predictors of risk. It does not however make up for the observation that occurs on the front lines. However, the subjective observation and diagnosis process is not a good predictor. Objective data is inherently too late for prevention. So, the goal is to use objective data to modify subjective assessments. The closer these two align, the better value-based care plans become at using front line caregivers to modify care plans at the point of care with a high degree of certainty. It's a continuous process of comparing what is initially thought as a good prediction against what actually happened.

Respondent 7:

Projections indicate that the population health management (PHM) market should reach $45 billion in 2021 up from $13 billion in 2016. In short, there will be a flurry of PHM data management options

available to providers in the next few years. The question is: which data management systems will deliver data aggregation solutions that support care coordination, patient engagement and analytic based decision-making? (Source; Modern Healthcare, 9/16/19).

Respondent 8:

Harnessing patient data to drive performance improvement is a big challenge in population health management. Establishing interoperability between health information systems is a constant struggle, and it seems the biggest roadblocks are not always technical in nature. Health and medicine in the future could look totally different in this country if we could just figure out how to pay everyone on value, establish secure connectivity between systems so we can share data to better care for patients, and create pathways for new medical innovations that can foster improved health and prevention. Once our industry fully embraces population health, I envision a future where providers prescribe technology applications to their patients such as fitness applications to encourage fitness, as well as motivate patients to make healthier behavior choices. These apps could be a cost-effective way to emphasize prevention and could also be used to provide ongoing education to patients about their health. The use of mobile technologies could also extend into the diagnostic realm as well. The marriage of healthcare and patient-interfacing technology could transform medicine in a way where we no longer view the human body as a black box where we take clinically educated guesses based on x-rays and blood tests. Instead value-based care could be a catalyst to finally unlocking the medical benefits of human genomic mapping. In order for all of this to happen, I do think the federal government will be needed to provide the needed push towards democratizing patient data so it can be more readily shared amongst providers caring for patients.

5. **<u>We know Primary Care is the key to patient attribution in a value-based agreement, but what about the role of Specialists and Ancillary providers in coordinating outcomes-based care?</u>**

Respondent 1:

PCPs are absolutely the key. With regard to specialists, they need to focus on a few items from my perspective: 1) be quickly available to accept a referral 2) ensure that any procedural care is delivered at the highest quality/lowest cost setting (use of ASCs, freestanding imaging, etc.) 3) develop a mechanism for providing timely information about the treatment plan that may exist back to the PCP and the subsequent care manager if one is engaged. A far-reaching goal would be for some of the medical specialties who are managing chronic conditions to encourage their members to have a medical home (PCMH).

Respondent 2:

Immense question, and really important. PCP's account for < 10% of total cost of care, but influence 80% of spend. I think patients need a medical home, PCP's need to be the quarterbacks and at the center of care. Specialists need incentives aligned to pay attention to cost of care and make new types of decisions: Is a 1% improved outcome worth a 10-fold increase in cost. Hard decision. Too much to write.

Respondent 3:

Specialists play a critical role in managing beneficiaries at risk for high utilization and spending. We try to incent our specialists in similar ways to support primary care providers: we place a premium on accessibility to their practice and their ability to see high-risk patients regularly to avoid unnecessary ED use and hospitalizations. Specialists are critical for our network in building new and innovative clinical interventions to manage disease-specific high cost areas. Specifically, we're in the process of building a CHF, COPD and extensivist clinics to prevent unnecessary hospitalizations. All of these are overseen and built by specialists (cardio, pulmonary and hospitalists, respectively).

Ultimately, specialists in a value-based care world will be commoditized in the same way that SNFs and hospitals are: only the highest value (low cost, high quality) specialists will be a part of networks participating heavily in VBC. So, their role is critical, but they should be wary to ensure they are the highest value specialists in their market relative to their competitors.

Respondent 4:

Use a narrow network of specialists when possible and consider incorporating ancillaries within the practice as justified financially.

Respondent 5:

Value-based provider plans are getting better at filling PCP gaps. For example, let's consider a migraine patient who sees their neurologist monthly. If there is a low prevalence of PCP involvement, PCPs should try to amp it up by helping the patient understand the need to use primary care to better manage the complexity and comorbidity of their condition. PCPs should promote AWVs and use care teams to reinforce the message. This process takes more time in a provider market that tends to refer a lot. Rural PCPs tend to be more comprehensive in providing patient care and use specialists as ancillary providers. Multispecialty groups tend to refer internally so it is important to coach specialists when to send patients back to their primary care provider.

Respondent 6:

It's all about communication when it comes to effective PCP/Specialist/Patient involvement in coordinating outcomes-based care. The specialist should use the consultation as an opportunity to provide the PCP with clinically relevant information and provide the patient with education about their diagnosis and plan of care. The PCP should give the specialist helpful feedback and ongoing information about the patient's care. In turn, the patient should provide feedback about their experience with the treatment plan.

"The focus on the consultation processes is a key step toward fostering patients as informed health care consumers and physicians as navigators. Even when the patient may decide as a consumer not to follow through on the consultation, the referring clinician should be aware of this decision in order to appropriately modify the treatment plan.

In short, the physician navigator needs to track the consultation in order to make sure nothing falls through the cracks, or to determine reasons for patient hesitancy." (Source: "How Physicians Can Navigate to Get Better Value from Specialty Services", Thomas Dent, MD. Co-Founder, Roji health Intelligence Blog, 10/9/19).

Respondent 7:

Integrating specialty care can be key for high performance and financial success for ACOs, as the most complicated and costly patient care usually is managed by specialists. Specialists are responsible for most medical and surgical procedures, involving both inpatient and outpatient care so Primary care-based ACOs need to be thoughtful about how to integrate specialists and ancillary providers in coordinating outcomes. Aligning economic incentives for specialists to participate will be of paramount importance. ACOs will also need to compile and share data to raise awareness of specialty practice variation in order to influence referral patterns.

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