How the CMS National Quality Strategy Can Guide your Value-Based Care Journey

Part 2: Using Innovation Center Models to Drive Efficient Specialty Care

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VBCExhibitHall.com
Educational Webinar Series

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About Roji Health Intelligence

- We provide Value-Based Care technology and services to improve outcomes, cost performance, and equitable health care.
- Our powerful tools identify patients at risk and target health interventions.
- Roji Health Intelligence is a CMS-qualified registry for QPP reporting, and we report eCQMs and CQMs.
- Roji Episodes reveal cost variations and cost drivers to generate strategies and interventions to address Total Cost of Care.

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This Presentation is For:

- ACOs evaluating affordability and looking to enhance savings
- Medical groups interested in maintaining consistent revenues
- Any organization on path to risk and considering value-based payments like population-based payments or capitation
- Health systems, medical groups and ACOs negotiating contracts with risk features

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Charting the Course

- Part 1 Recap: Lessons Learned and the National Quality Strategy
- Specialty Care Integration, Phase 1: Cross-Cutting Specialty Care
- Specialty Care Integration, Phase 2: Addressing Specific Needs
- Creating a Cohesive Network - No More Silos!

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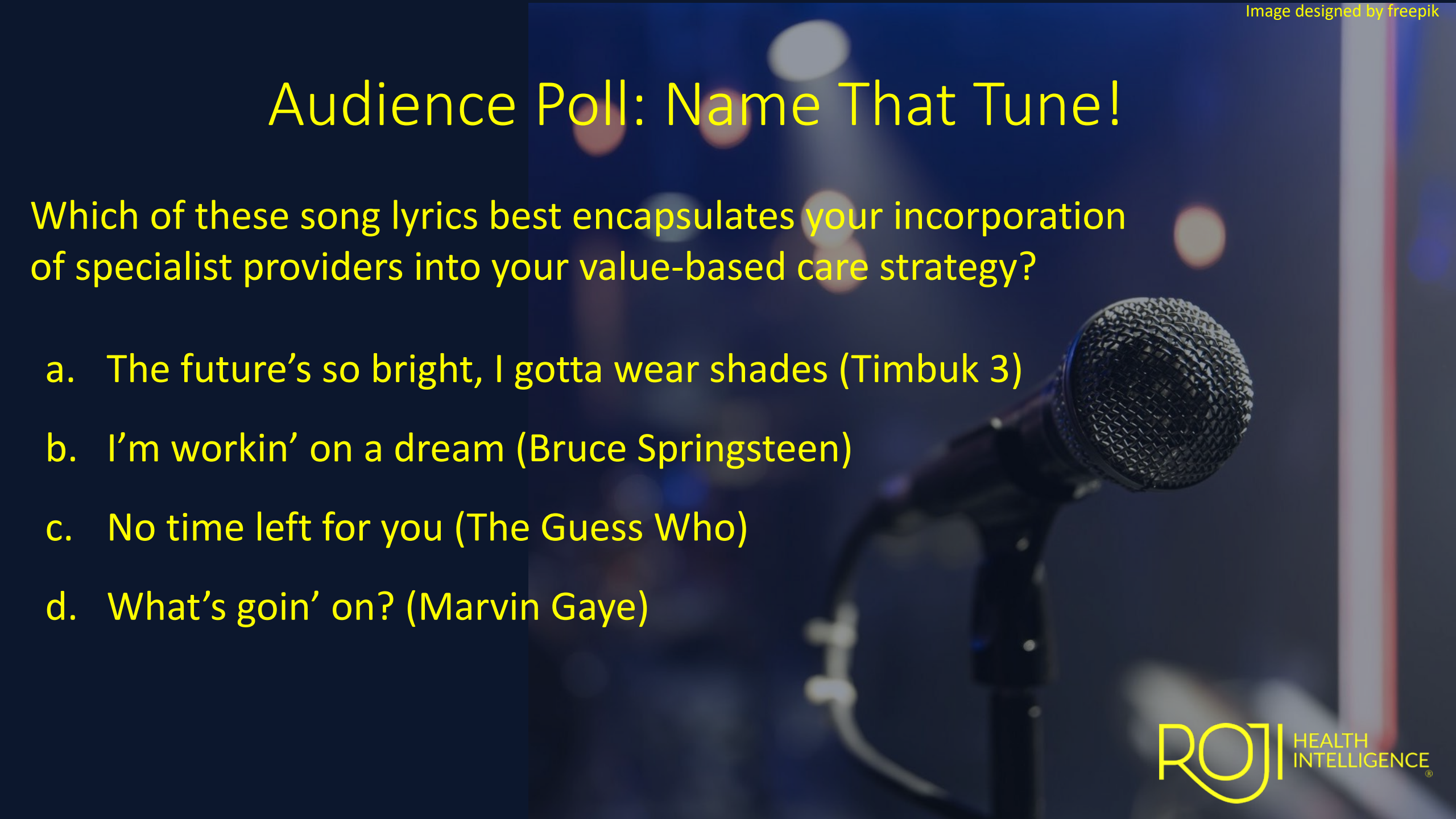

Audience Poll: Name That Tune!

Which of these song lyrics best encapsulates your incorporation of specialist providers into your value-based care strategy?

a. The future's so bright, I gotta wear shades (Timbuk 3)
b. I'm workin' on a dream (Bruce Springsteen)
c. No time left for you (The Guess Who)
d. What's goin' on? (Marvin Gaye)

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CMS Innovation Center's Lessons Learned

- Health Equity must be addressed to create meaningful transformation
- Models need to be simplified, and complement each other
- Recognize that investment is required in order to succeed under risk
- Financial benchmarks were unclear, and selection bias did not help
- Top-down dictation eventually leads to backsliding

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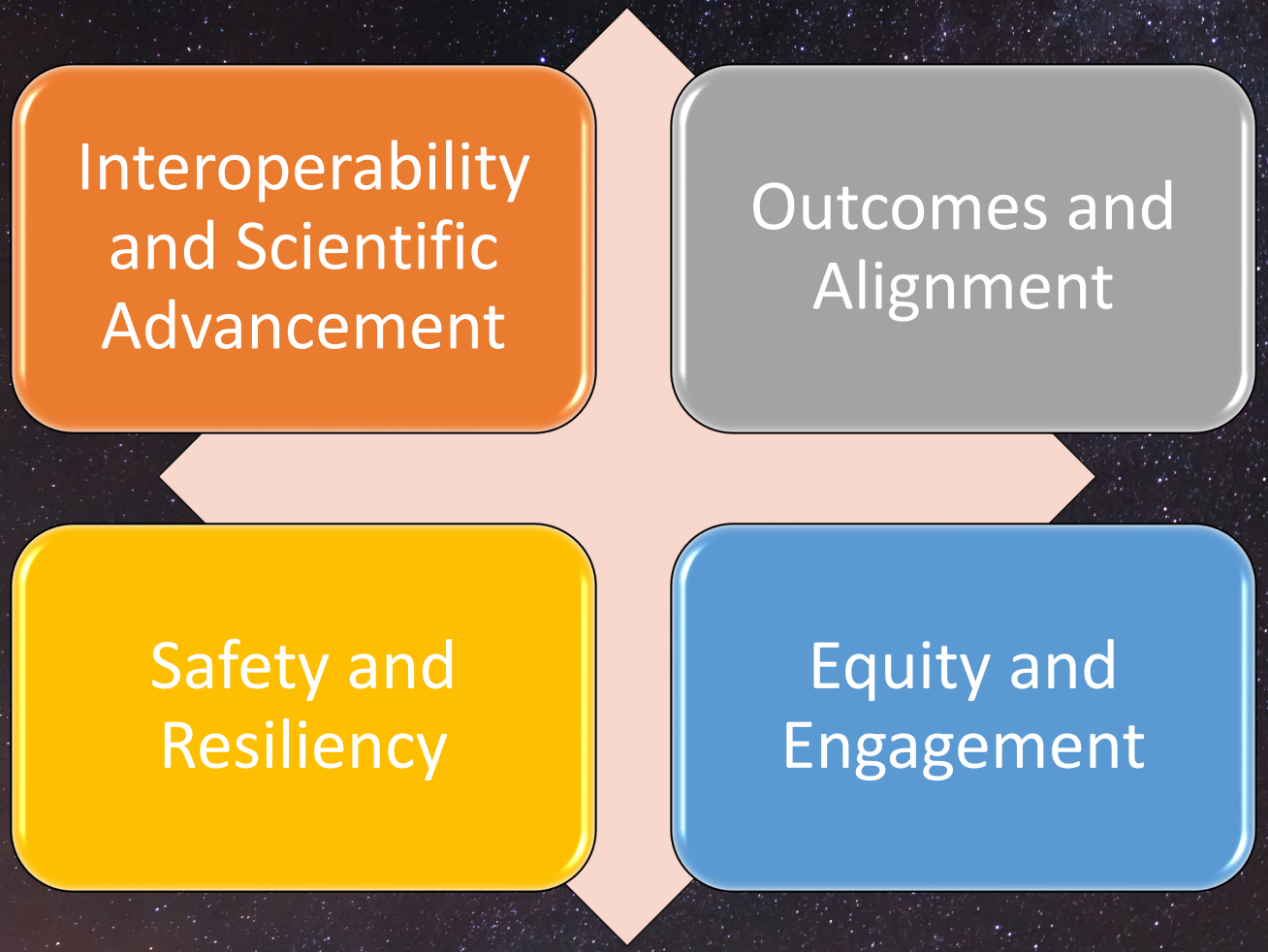
The National Quality Strategy



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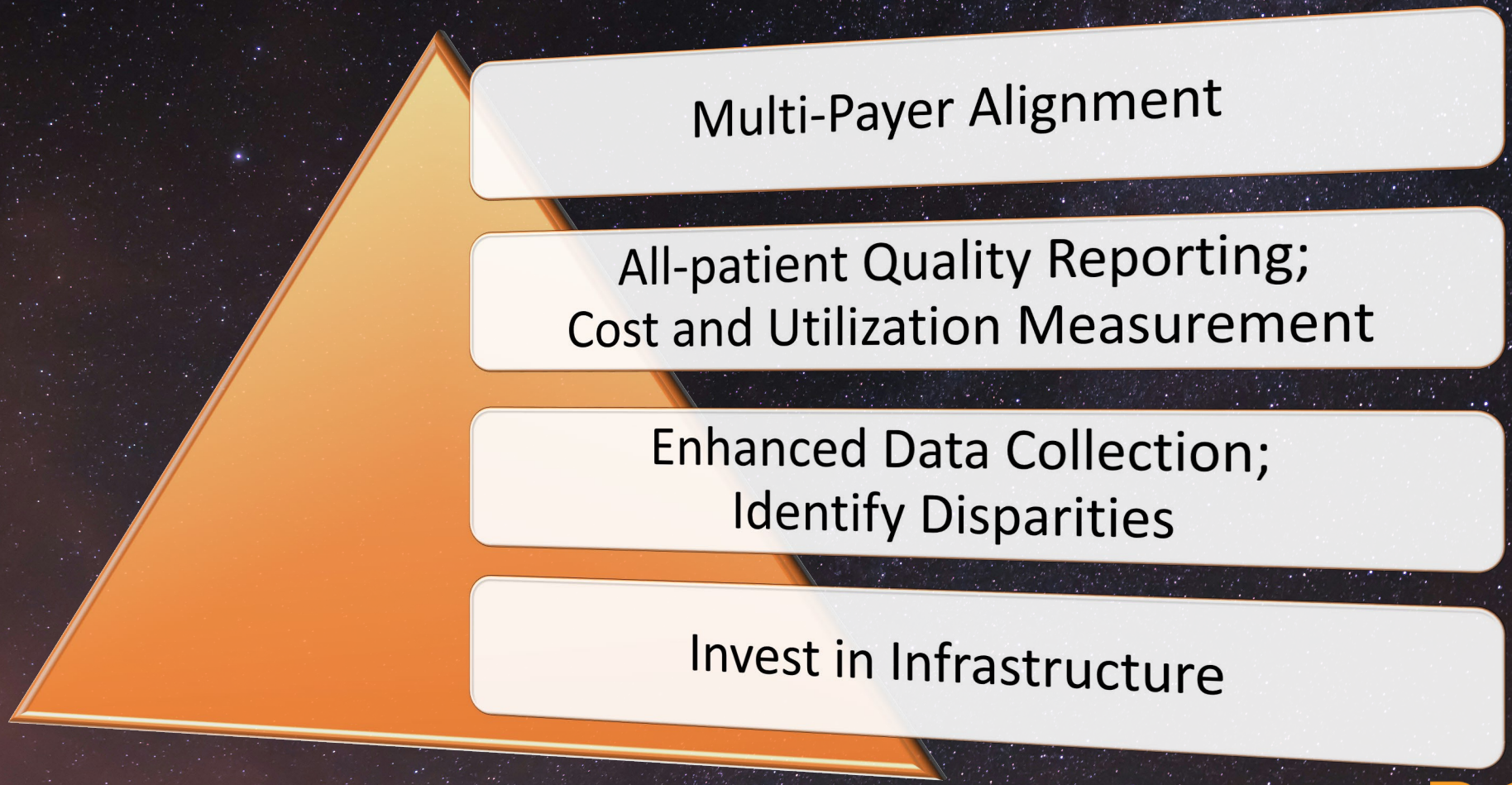
Adapt CMMI Models to Create Your Program



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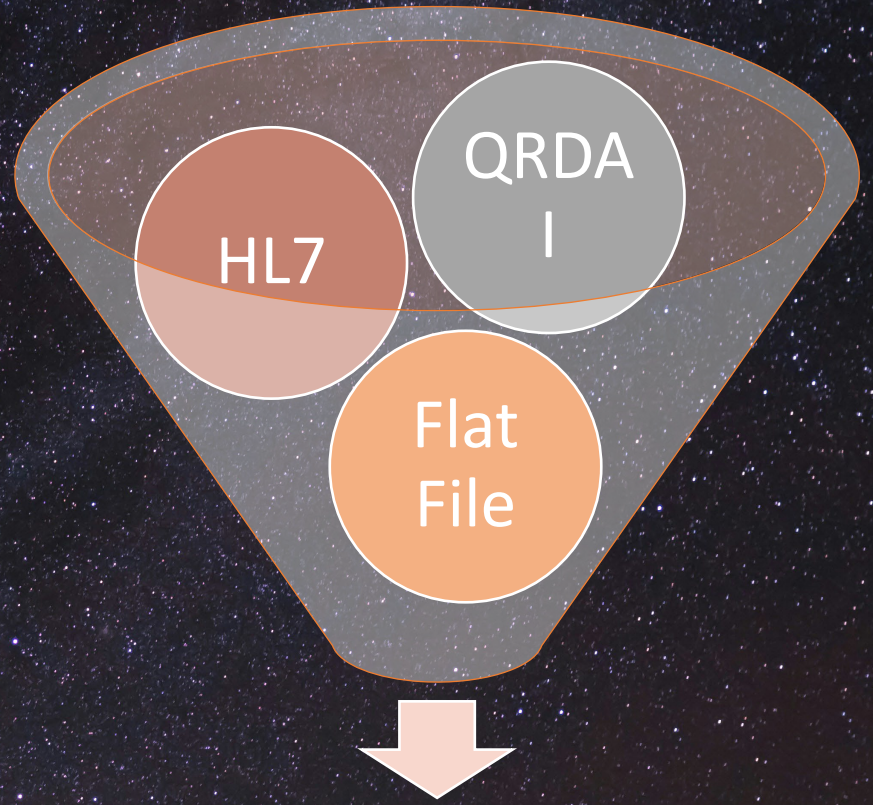
Data Aggregation is “Must Have”

- Essential to track patients across the continuum of care
- Clinically relevant interventions require a comprehensive, patient centric view
- QRDAs alone are not sufficient; they are limited to quality measure values



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Cross-Cutting Specialty Care Produces Broad Results

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Specialty Care ≠ Excess Cost

- 40%-60% of total costs are tied to care provided by specialists
- Your goal: Coordinate specialty costs
- Your challenge: Collaborating with specialists to produce optimal results
- Your pathway:
  - Strategically apply your scarce resources (time, effort, investment)
  - Use data-driven methods to ensure optimal and efficient care

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Where Should You Start?

- Dollars don't tell the whole story - one expensive case shouldn't dictate development!
- Some specialty care applies more broadly than others
- Start where you can affect the most patients: Disease Progression
  - Prevents excess utilization
  - Directly improves Quality Measure results
  - Natural first step beyond primary care (or identify its absence!)

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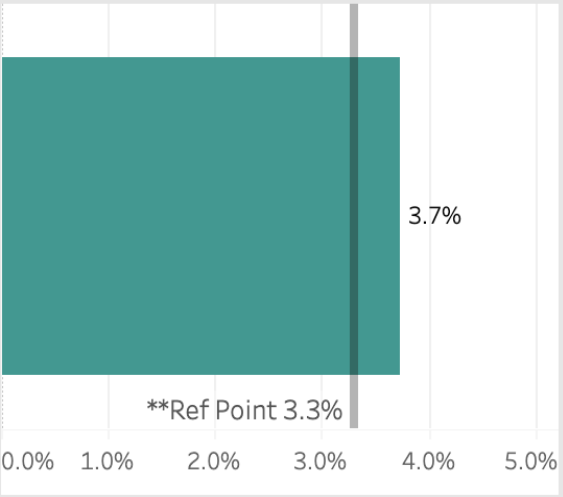
Select Year
(All)

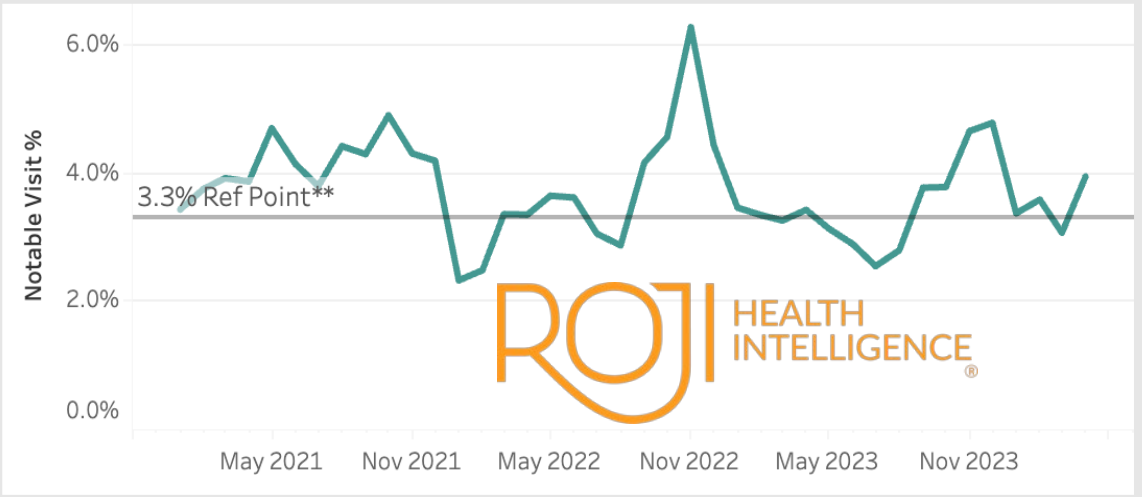
Notable Emergency Room Visits

128,357	4,785	3.7%	2,474	51.7%
ER Visits	Notable Visits	% Total Visits	Notable ER with NO prior PCP	Notable % with NO prior PCP visit

% of Total ER Visits

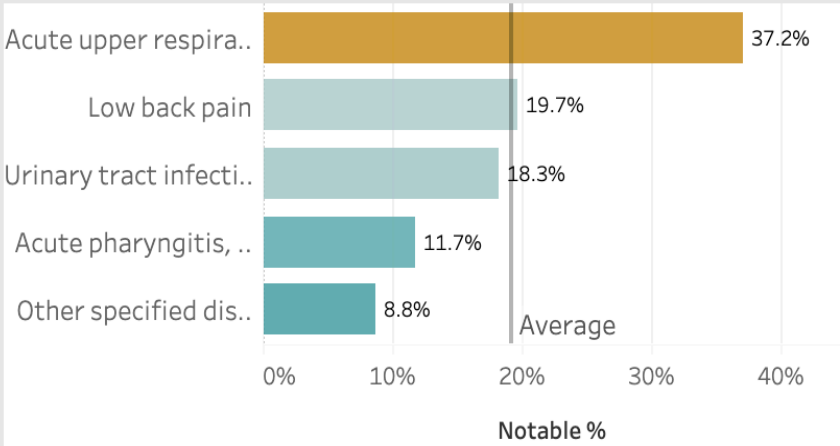


Notable ER Visit % by Month

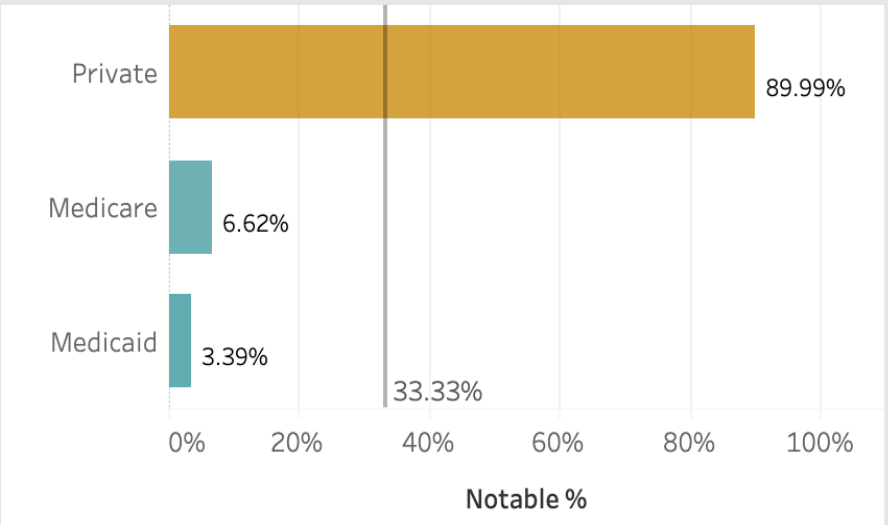


Top 5 Notable ER Categories

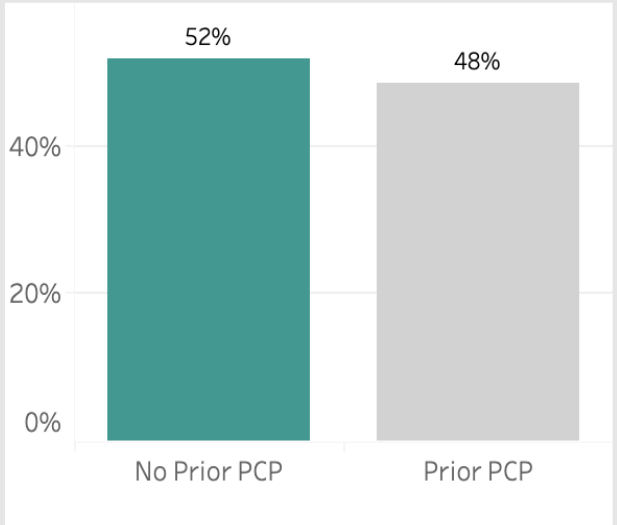
(by Catagory as % of Total Notable ER Visits)



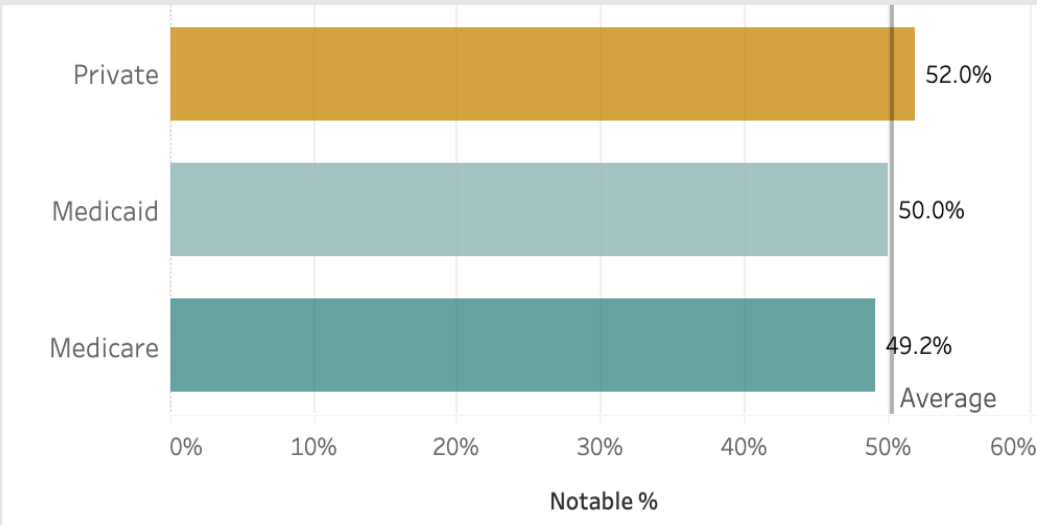
% Notable ER Visits by Payer



% Notable ER Visits w/wo Prior PCP



% Notable ER Visits with **NO Prior PCP** by Payer



Logical First Steps

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- Look at CMMI programs closely orbiting primary care to slow disease progression
  - Innovation in Behavioral Health (IBH)
  - Medicare Diabetes Prevention Program (MDPP) Expanded
  - Kidney Care Choices (KCC)

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Innovation In Behavioral Health

- Well documented links between BH and Substance Use Disorder (SUD) and impacts on chronic conditions
- Care Integration and Management:
  - Screening and Assessment of patient BH and PH needs, including HRSNs
  - Monitoring BH and PH conditions, adjusting plans if outcomes are “flat-line”
  - Whole-person, team-based care with beneficiary input
- Prospective payment and funding for infrastructure

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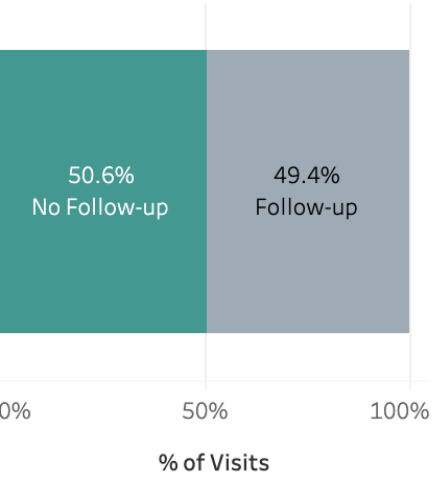
Select Year
(All)

Behavioral Health ER Visits

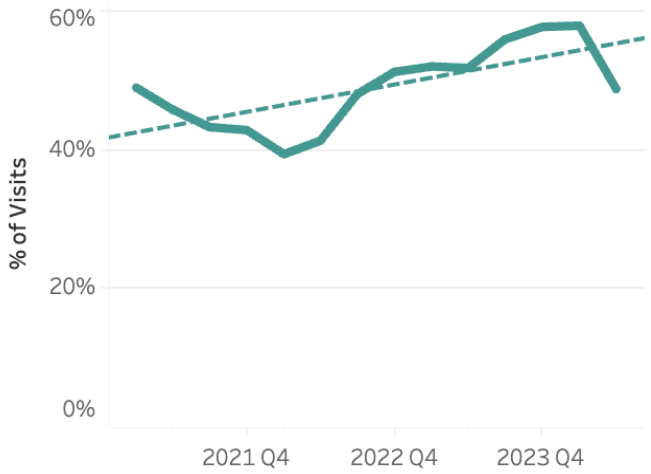
30
Patients with 3+ visits in past 90 Days
View Patients

3,583	960	6,681	3,379	50.6%
Total Patients	Patients Admitted	Total Visits	Visits WO Follow-up	% WO Follow-up

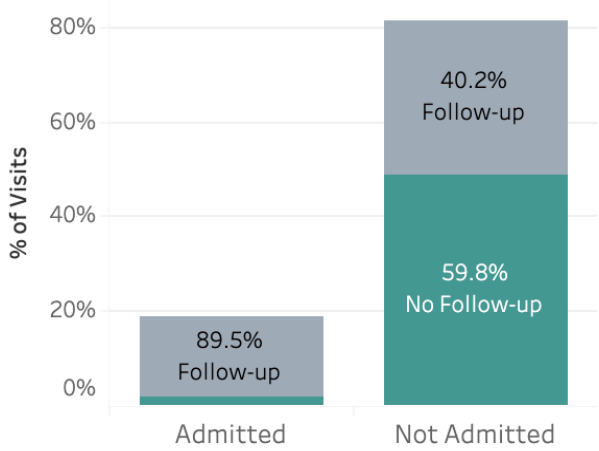
Follow-up Status



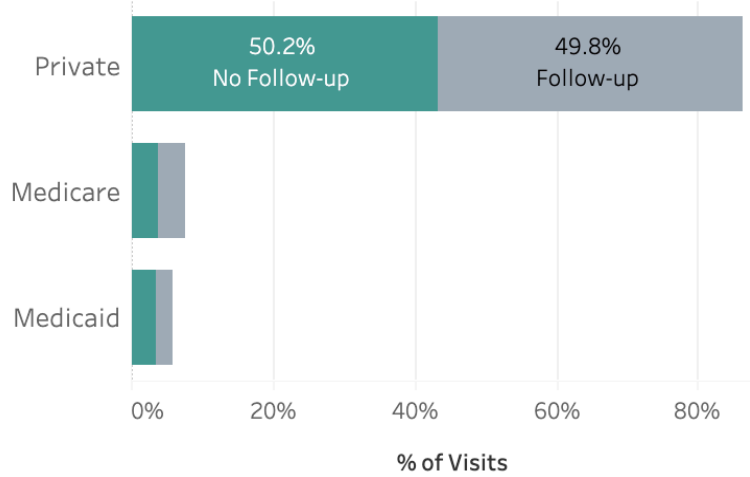
No Follow-up % Trend



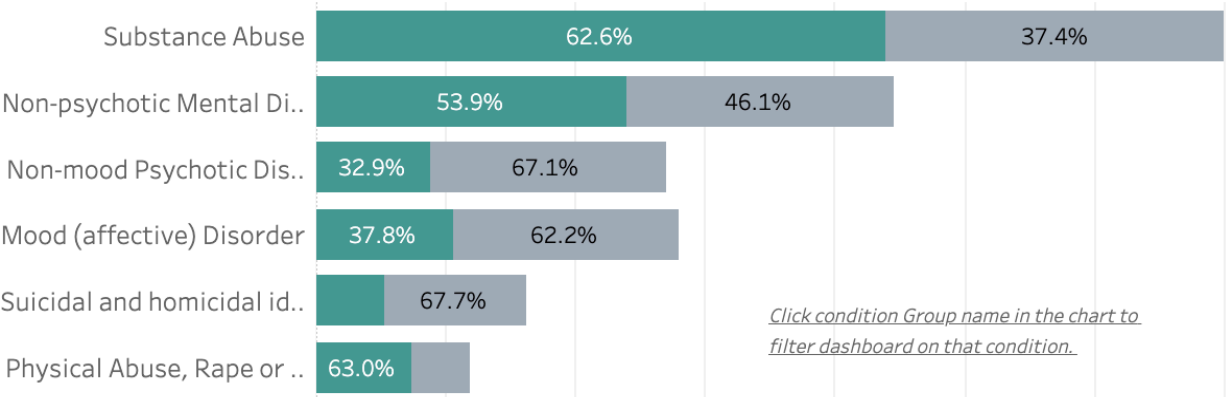
Admission and Follow-up Status



Payer Follow-up Status

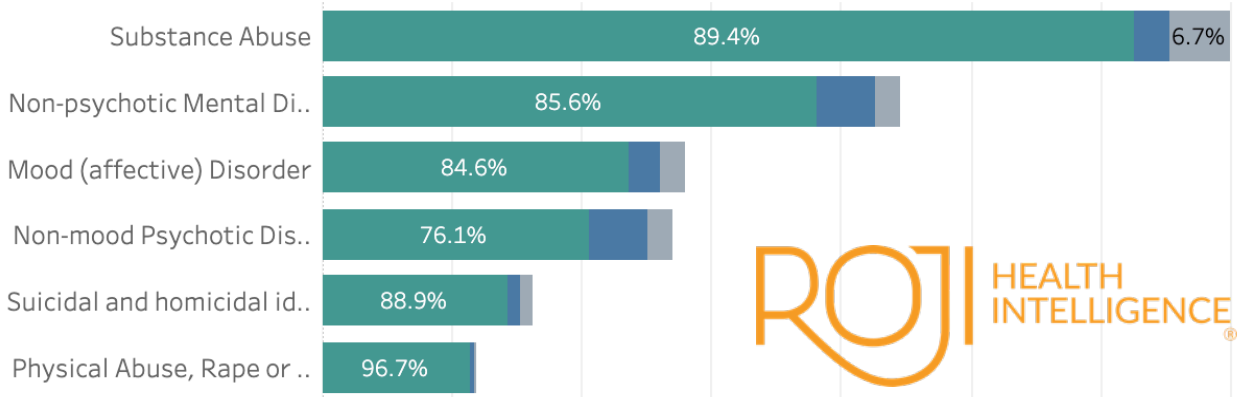


Visits for Condition by Follow-up Status



Click condition Group name in the chart to filter dashboard on that condition.

Visits for Condition and Payer



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Medicare Diabetes Prevention Program

- Type 2 diabetes affects more than ¼ of Americans aged 65+
- $205 Billion spent on diabetes care for Americans aged 65+ in 2022
- 1 in 2 over 65 have prediabetes, but only 1 in 7 know!
- Short-term (1 year) data-driven BMI goals, supported by behavioral counseling

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Populations

Populations and Groups

Refresh | Manage

	Name	Patients
▸	[redacted]	566
▸	[redacted]	688
▾	[redacted]	1654
	[redacted]	351
	[redacted]	418
	[redacted]	278
	Obesity, No nutritionist/Dieti…	713
	[redacted]	476
	[redacted]	106
▸	[redacted]	6694

All Practices

Description | Notes | Interventions

Name: Obesity, No nutritionist/Dietition Visit

Start Date: 2014-05-21

Description: Patient with Obesity (BMI >=30) WITH NO medical nutritional therapy or nutritionist/dietition visit

Interventions:

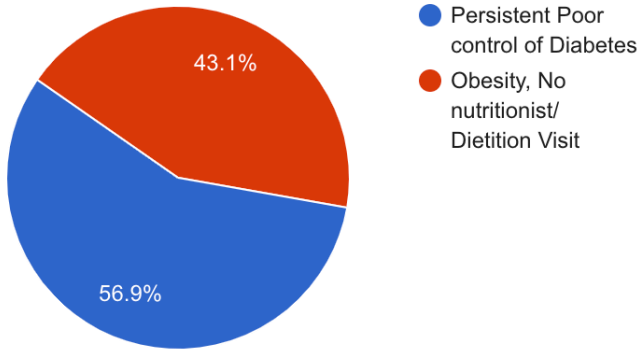
No interventions associated with this project.

Data Filter

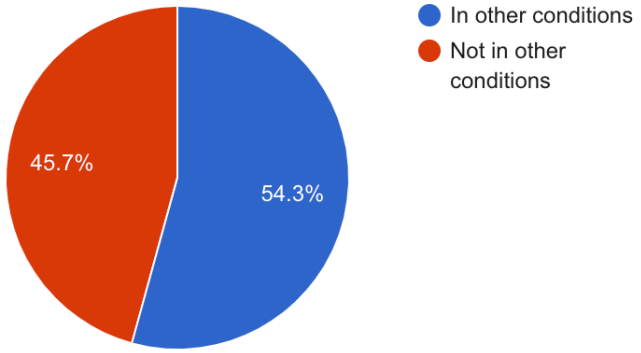
Overview | Trends | Patients | Outcomes | Actions

Refresh

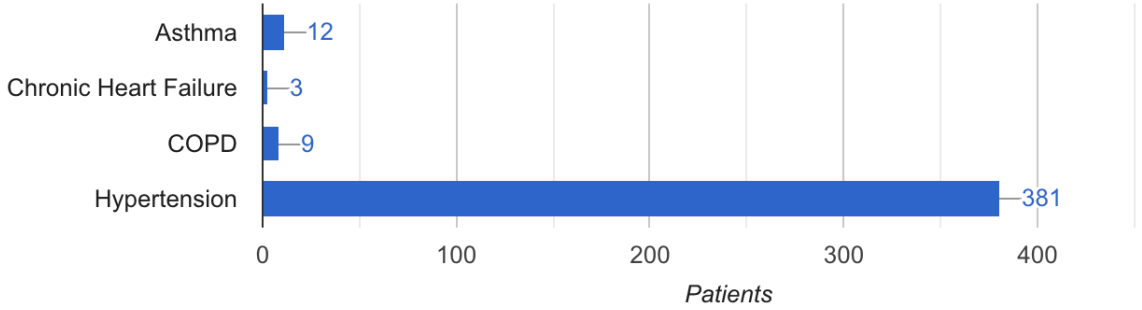
Patient Population



Obesity, No nutritionist/Dietition Visit



Episode Conditions



Populations

Identify, Intervene, Improve!

Populations and Groups

Refresh | Manage

	Name	Patients
▸	[redacted]	566
▸	[redacted]	688
▾	[redacted]	1654
	[redacted]	351
	[redacted]	418
	[redacted]	278
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All Practices

Description | Notes | Interventions

Name: Obesity, No nutritionist/Dietition Visit

Start Date: 2014-05-21

Description: Patient with Obesity (BMI >=30) WITH NO medical nutritional therapy or nutritionist/dietition visit

Interventions:

Data Filter

Help

Patient Last Name LIKE:

(a) Age ≥: 11

(b) Age ≤: 90

Inclusion Criteria (Click all that apply):

Provider (Click all that apply):

Sort By: Patient Name

Sort Direction: Ascending

Can Contact: N/A

Communication Preference: Any

Payer: Any

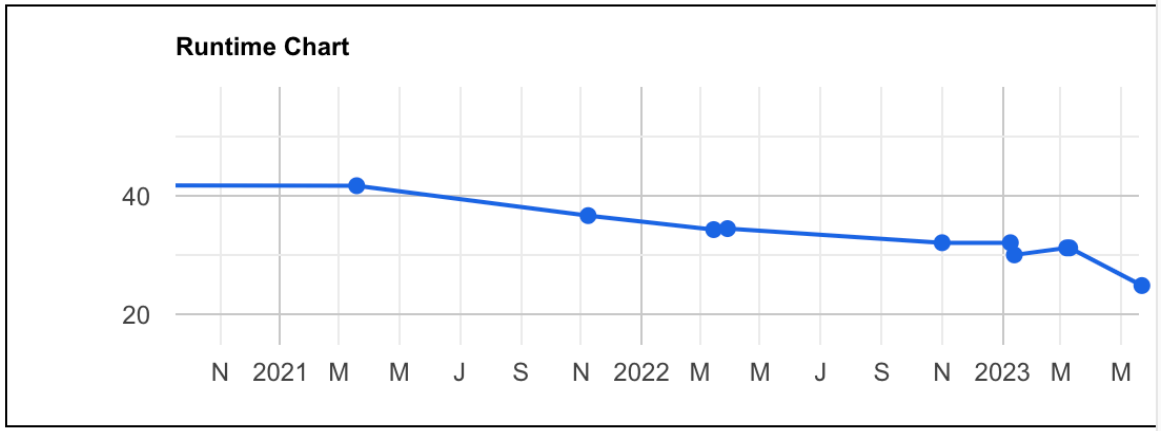
Overview | Trends | Patients | Outcomes | Actions

Refresh | Export

#	Patient	DOB	A1C	BMI	BP-S
212	[redacted]	1995-…	10.50	51.48	126
213	[redacted]	1973-…	5.70	24.95	125
214	[redacted]	2005-…	9.10	29.57	118
215	[redacted]	1958-…	8.60	58.94	113
216	[redacted]	1973-…	12.80	35.02	158
217	[redacted]	1975-…	15.00	32.83	138

Analytics

Click and drag over an area to zoom. Right click to reset chart.



Kidney Care Choices

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- For patients with CKD, put the brakes on ESRD and Dialysis
- Improve patient experience and reduce total cost of care
- Coordinate care to prevent kidney failure, reduce dialysis rates, improve transplant access
- Upfront investment, with risk options varying by participation options

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Address Specifics by Branching Out

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Incorporating Episodes of Care

- Episodes of care analytics for conditions and procedures are the key tool to evaluate cost variations and view the data
- Episodes must be clinically focused
- Within each episode, you can compare what services and costs vary
- Episodes can reveal cost drivers and factors that appear to drive both cost and quality, for discussion with physicians

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Example Episode-Based Care Measurement

- CMMI Model Examples
  - Bundled Payments for Care Improvement (BPCI) Advanced
  - Transforming Episode Accountability Model (TEAM)
  - Enhancing Oncology Model (EOM)
- Merit-Based Incentive Payment System (MIPS) Cost Measures

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BPCI Advanced

- Rationale: Procedures and hospitalizations result in care fragmentation
- Methodology: Move responsibility for communication from patients to the BPCI participant
- Goals: Successful recovery, reduced readmissions and complications
- Measures: Total Cost of Care + Quality Measures within the window
- Buyer Beware! TCOC includes all costs in the episode window
- Different procedures bundled together – loses clinical integrity

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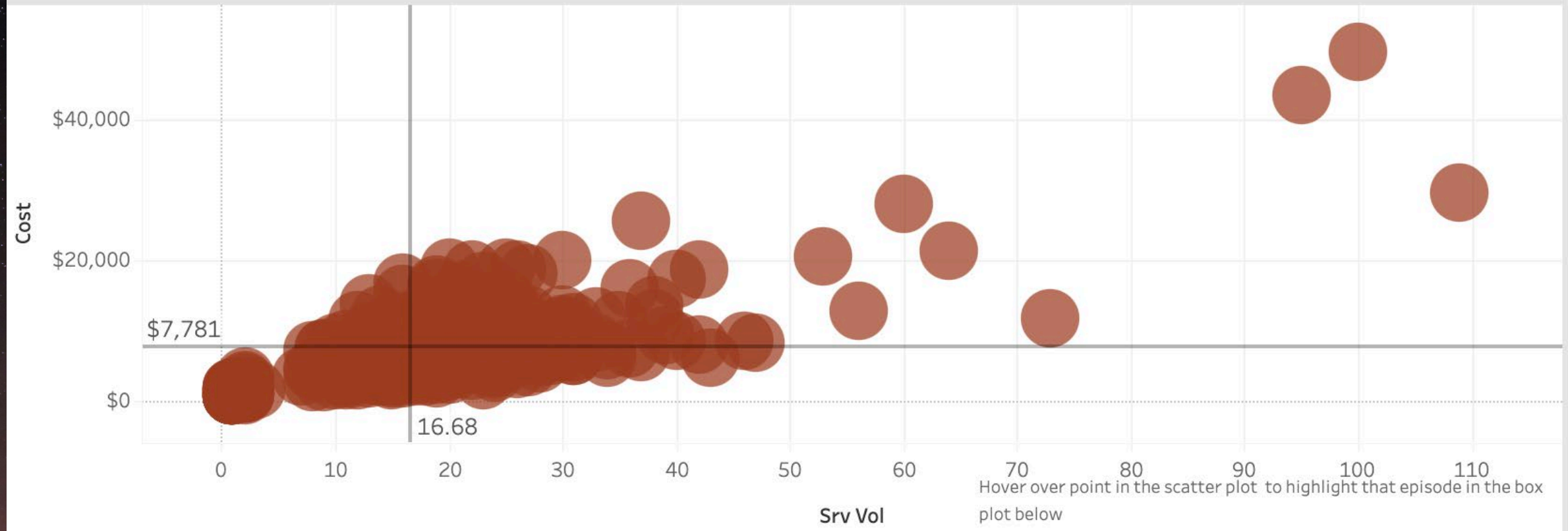
Episodes: **Lumbar spine fusion**

For Category: ***All*** *For Service:* ***None***

For Provider: **All**



Episode Cost Range by Category

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Enhancing Oncology Model

- Unburden patients receiving chemotherapy from coordinating their own care
- Oncology quality measure reporting + administrative claims measures
- Upfront investment, bonuses (or recoupment) following evaluation
- Multi-payer alignment, with emphasis on health equity
- Specific focus on patients with comorbidities to ensure care continuity

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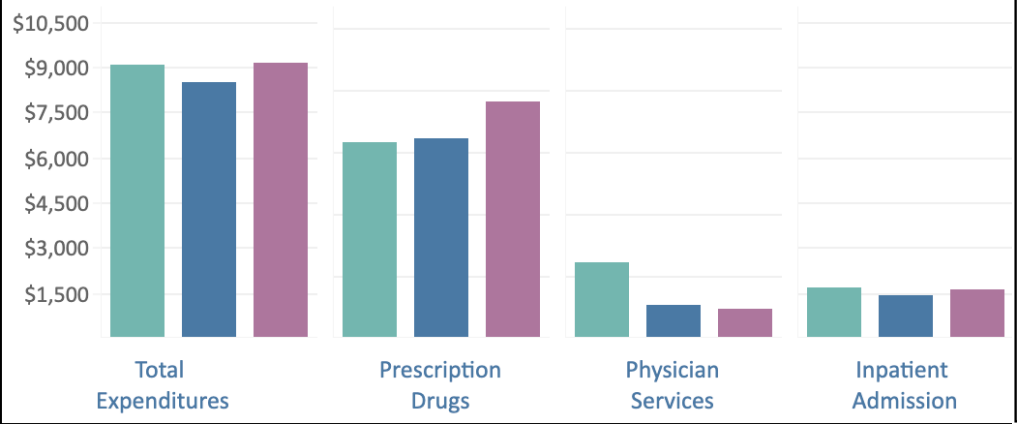
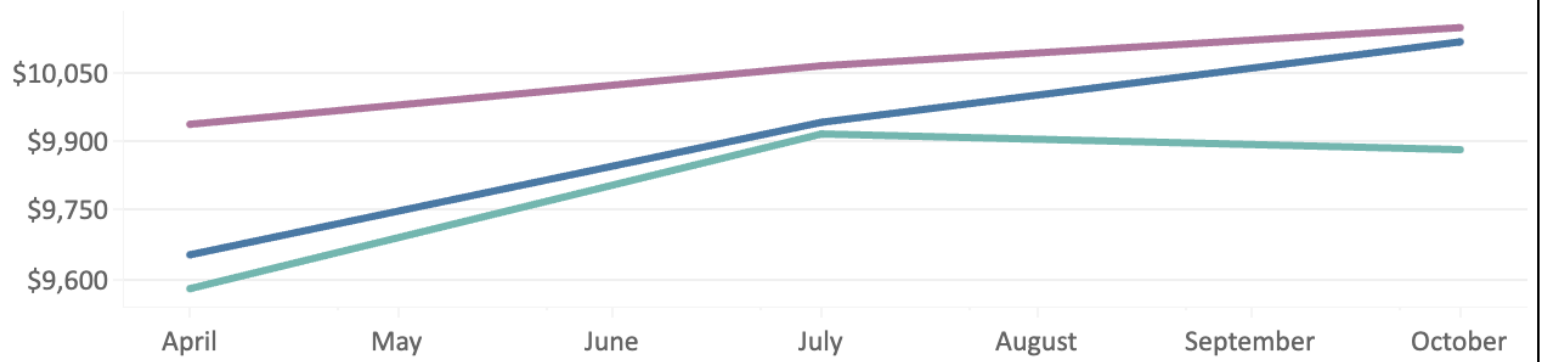
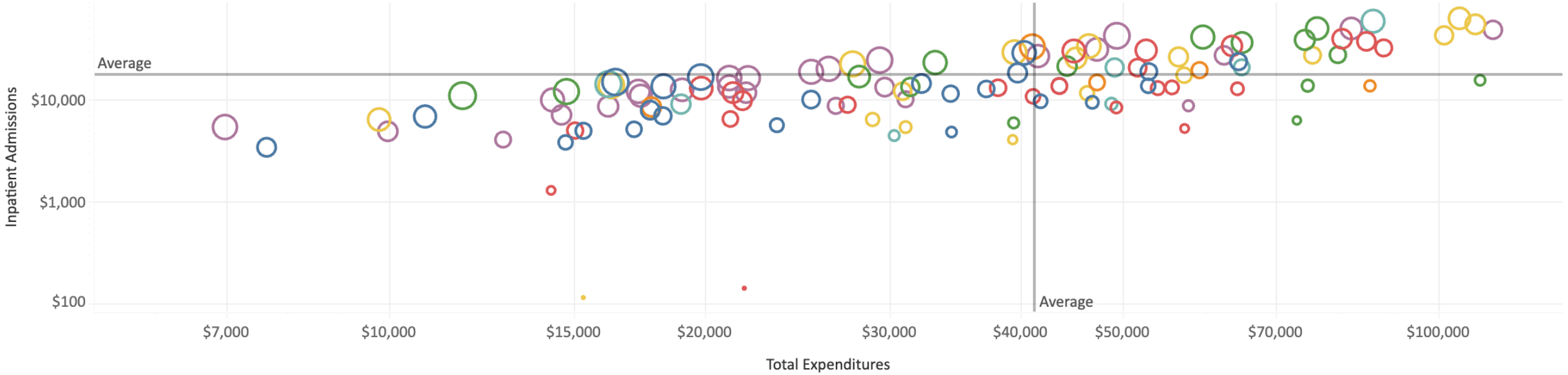
Top Medicare Expenditures Categories



Total Medical Expenditures



Inpatient Admissions Expenditures/Total Expenditures



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Transforming Episode Accountability Model

- For LEJR, Surgical Hip/Femur Treatment, Spinal Fusion, CABG, and Major Bowel Procedure:
  - Avoid ED and IP visits (or shorten stays)
  - Faster recoveries after procedures
  - Transition back to primary care
  - Create equitable health outcomes
- TEAM procedures dovetail with MIPS Cost Measures

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MIPS

- 15 procedural episode-based cost measures
- Episode window: +/- 90 days pre-trigger and +/- 90 days post-trigger

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Who's on First?

Someone performed the trigger procedure

But…should all costs within the window be tied to them?

Not all high cost episodes are preventable—focus on what can be controlled!

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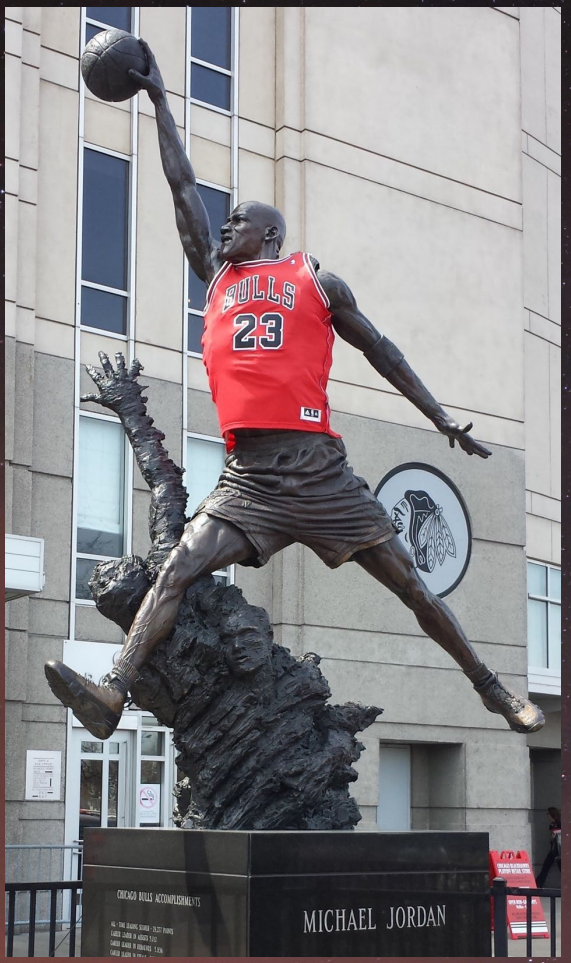
Options Beyond CMMI Models

(No, not him)



Unsplash.com

- MIPS Value Pathways (MVPs)
  - Specialty and/or clinical set of Quality Measures, Improvement Activities and Cost Measures
  - Breaks the barriers between MIPS components
  - Facilitates comparison by standardizing clinician performance
  - Potential future as an ACO component for specialists
  - Ensure QPP compliance for everyone in your organization (not all APM participants will be QPs)

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Creating a Cohesive Network

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How Do Specialists Benefit?

- Facilitates success in quality reporting
- Offload PC services; proper attribution for MIPS Cost and APMs
- Ensures a steady stream of referrals
- Access to episodic care insights
- Demonstrable excellence can be used in negotiations with other health plans

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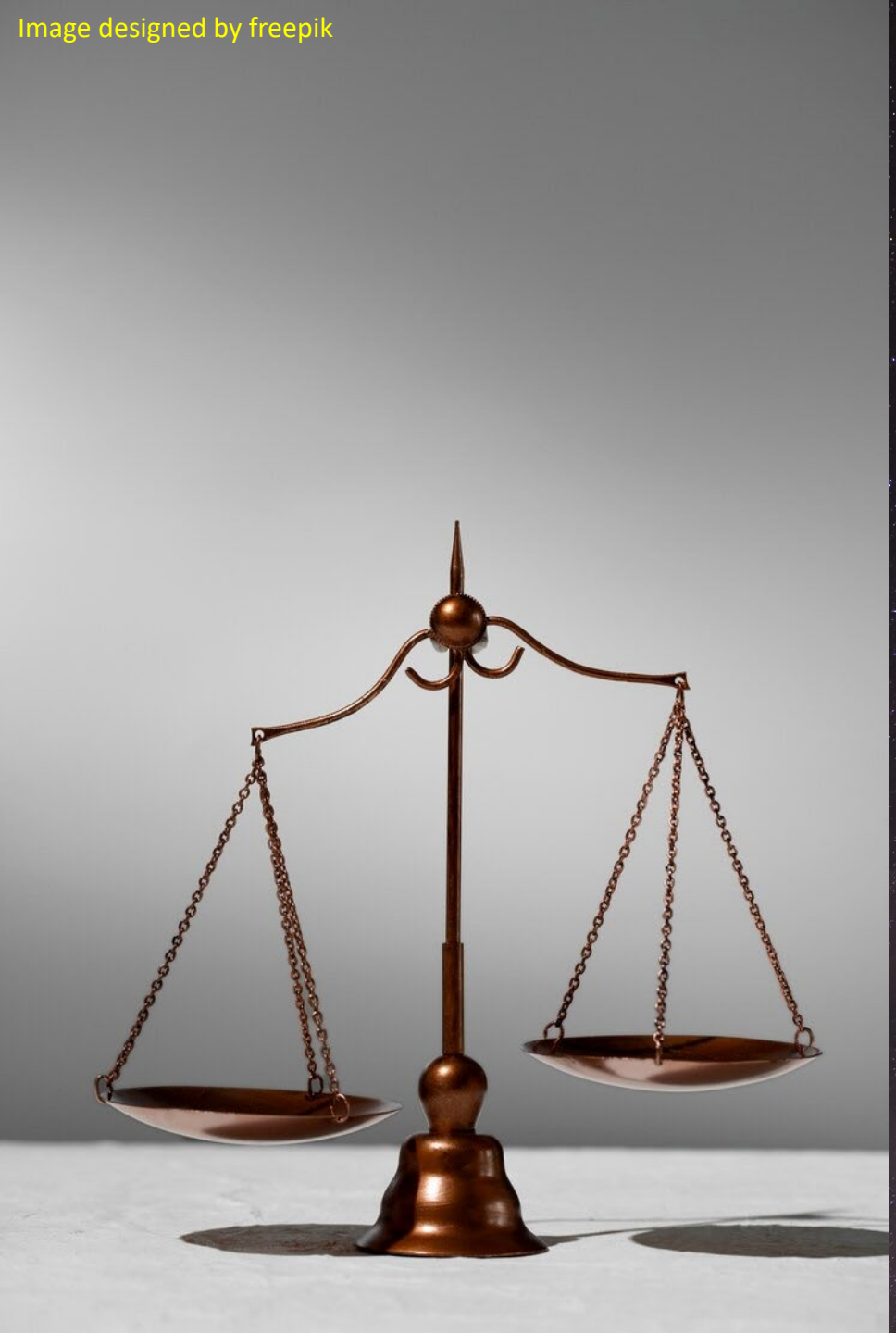

A Balancing Act

- Previously private (or unknown) cost and quality results go beyond the specialty group
- Trust in data privacy and security is paramount – exclusively used for patient care
- Delicate balance, but improves care and creates a bi-directional referral pathway

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Pillars of Each VBC Program

- Separate programs, but united by several factors:
  - Patient-centered care
  - Multi-payer alignment
  - Health equity
  - Meaningful quality and utilization measurement, in addition to Cost

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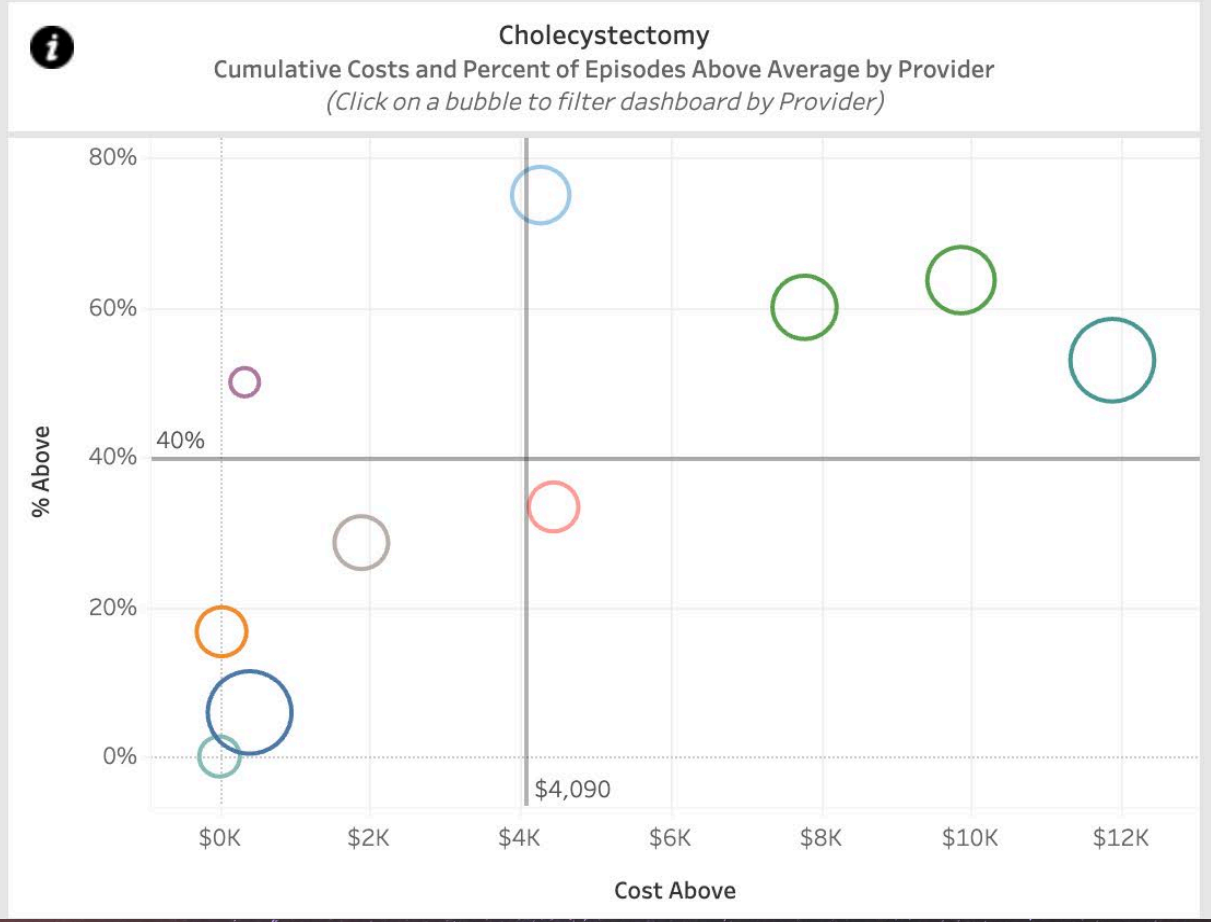
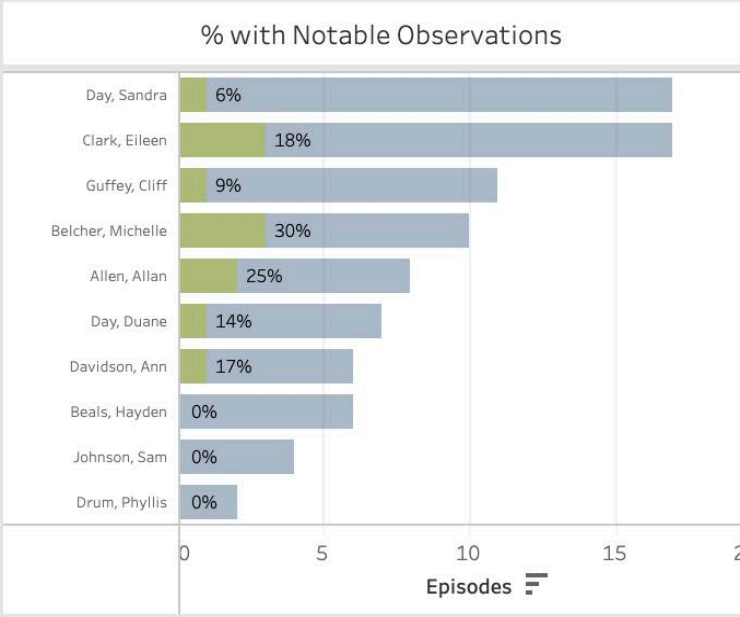
Identifying Variations By Provider and Site

Episode Cost by Provider for Cholecystectomy

Total Episodes	Total Cost	Average Cost	Episodes Above Average Cost	% Above Average Cost	Cumulative Cost Above Avg
88	$184,422	$2,096	35	40%	$40,898

Clark, Eileen
has the Highest cumulative costs over average
$11,879
Cholecystectomy





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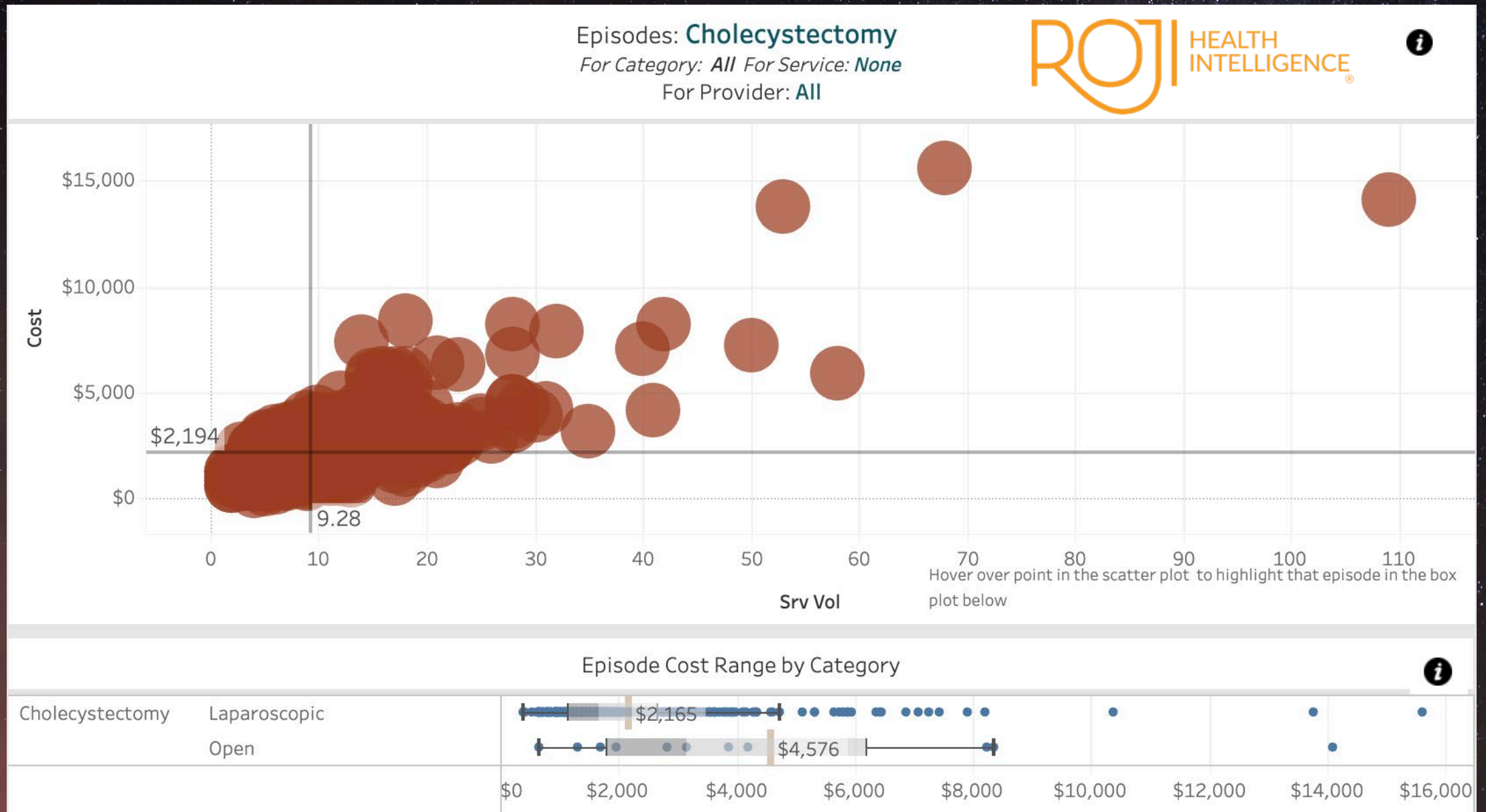
Episodes
NO Episode Vol

Investigate Root Causes of High-Cost Cases



Questions and Answers

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Stop by our Value Based Care Exhibit Hall Virtual Booth

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Visit the Roji Heath Intelligence Booth

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Thank You!

Contact us to make your VBC strategy successful!

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