CEO Leadership Series: Vol 14

Exploring the mechanics of a value based care platform, what does it take from an operational standpoint?

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Key Takeaways

Successful execution in risk-based models requires investment in mostly additive teams, skillsets and operational strategies relative to traditional fee-for-service care delivery

Effective value-based care draws upon specialized programs and a full team approach versus solely upon a MD-centric model. Achieving contract measures is not just an ask of the MD, it's an ask of the office team.

- Specialized operational programs extend the realm and nature of care
- Risk coding & clinical documentation
- Care management and transitions-in-care program
- Social worker care
- Transportation program
- Pharmacy management
- Value-based care contracting

- New approaches to problem solving – for example, how to mitigate the care & financial cost of poor medication adherence across patients who cannot afford their medications
  - **Old paradigm:** Problem often left unaddressed without any clear solution
  - **New paradigm:** Dedicated teams responsible for tapping into the full range of community resources to fill the medication order through normal channels and / or grants, foundations, manufacturer programs, low-income subsidies and other available programs
- Newly additive programs require investment – aim to match the pace of infrastructure development with the contract terms and progression to full risk so that your infrastructure maturity is ideally never too far ahead or behind the contract terms

Challenges Remain to be Worked Through as the Value-Based Care Market Matures

Medicare provider shared savings incentive models based on beating prior year personal benchmarks risk sustainability questions due to diminishing provider returns / incentives over time as prior year benchmarks become harder to exceed. Resulting provider turnover in Medicare ACOs has already contributed to adjustments to the Medicare incentive model.

Many value-based care models and service providers only focus on particular payer lines of business and do not address the holistic patient ecosystem, resulting in:

- Fragmented care models that only address specific lines of business (e.g. Medicare Advantage)
- Complex webs of disparate and disconnected service providers across lines of business

Certain structural challenges from the fee-for-service paradigm persist

- Patient populations deemed to represent greater value are highly sought after; the care and financial burden of other more challenging and less well-funded patient demographics continues to fall to safety net health systems
- Solving for uninsured populations remains challenging

On the Horizon in Value-Based Care

- Activity to-date has focused mostly on primary care. Expect to see more focus on specialty care models that better integrate specialty and primary care to more effectively treat particular conditions.
- Increased utilization of predictive and prescriptive analytics to further tailor the care experience to an individual patient's true needs
- In order to compete with the national players, health systems will increasingly offer new, more collaborative partnership models to providers beyond traditional employment. Intermountain Healthcare and its Castell Health program offer a glimpse into a potential model for health systems.

Background

Yates Lennon, MD, MMM, currently serves as the President and Chief Transformation Officer for CHESS Health Solutions. He is nationally known for his work in quality, previously serving on the American Medical Group Association (AMGA) Quality Leadership Council and presently on the National Association of Accountable Care Organization's Quality Committee. Dr. Lennon's background includes 23 years as a practicing OB/GYN and a Diplomat of The American Board of Obstetricians and Gynecologists. He served as Chief Quality Officer for Cornerstone Health Care before joining CHESS in 2018 as Chief Transformation Officer. Dr. Lennon assumed the role of President in 2021. He has a deep understanding of practice transformation and how to engage physicians and their staff.

His value-based care expertise allows him to translate his knowledge into initiatives that health care teams understand and can implement to ultimately transform patient care.

CHESS negotiates value-based payer contracts and risk-based agreements to reward providers financially for focusing on cost and quality. CHESS works closely with the Centers for Medicare & Medicaid Services (CMS) and manages several Accountable Care Organizations (ACOs), such as the ACO REACH model (CHESS Genesis, LLC) and the MSSP Shared Savings Program ACO models. (CHESS Innovation, LLC and CHESS Value, LLC).

Describe CHESS as an organization?

CHESS supports just over 220,000 lives in value-based agreements. We have several MA value agreements that range from shared savings to two-sided risk. We have 10 clients, all in Central and Western North Carolina. Primarily, they are health systems and their employed provider groups. The employed provider groups are who we work with most closely, but we involve the health system at varying levels in that process, depending upon how the system is set up. We do have one large FQHC, currently the second largest in North Carolina and it has been a great partner.

CHESS offers a turnkey value-based care solution to providers, health systems, and IPAs who have not yet started their value journey. For similar entities who are on their way but need additional support, CHESS offers tailored solutions that complement and supplement existing value-based care infrastructure.

We are eager to expand our footprint outside of North Carolina. COVID has presented many challenges and health systems continue to struggle financially. We continue to work closely with our value partners and still continue to grow, but would like to expand a little faster as we move forward. As things are beginning to get back to normal, we are having more conversations and in-person discussions than we have had in a long time.

CHESS today employs how many people in what function? And, the 200-plus thousand lives that you are responsible for, how does that break down in terms of number of clients that have signed service agreements with CHESS? What is the nature of those clients?

CHESS has 93 employees. Nearly half of those folks are nurses, certified medical assistants, clinical PharmDs and pharmacy techs. These teams perform the outreach to our population of 220,000 patients using our processes and algorithms to identify which patents need to be touched and how often. The rest of our team provides ancillary support to the value partner's clinical and operational teams.

Coding & Clinical Documentation Program

CHESS works closely with value partners on HCC and risk coding capture, making sure that the process is accurate and timely to capture the acuity of the patients' conditions. Accurate coding and documentation is vital to success in value-based care. We place an emphasis on compliance and integrity of these programs.

Implementation Program

We have a team of people that operationalize the value-based contracts in partnership with our value partners and their operational teams. As we work with physicians within a contract, we provide understanding to the providers and their leadership of the levers within the contract. It is important that providers understand what must happen to be successful both clinically and financially.

We also have an implementation team; They engage in the business development process to understand and assess a potential partner. Once we have signed agreements, this is the team responsible for implementing the programs that CHESS deploys. Many of our programs revolve around the CHESS care management team which focuses on managing utilization. Helping providers understand the work the care management teams perform to support them and their patients is critical to providers subsequently engaging with the program.

Transitions in Care Program

One key area of managing utilization is trying to limit and manage readmission and readmission risk. The CHESS care management team focuses on the transitional care process and on supporting the providers with the data and documentation necessary to be able to bill a transitional care management visit. The TCM visit pays what one might call a premium on top of a typical E&M code for engaging a patient in a timely fashion after they've left an acute care setting. Whether that be a transition from an inpatient setting in the hospital or from a skilled nursing facility - going from either of those to home - our nurses engage the patient and work with the CHESS pharmacy team, as needed, for medication reconciliation, medication management and/or medication assistance. Essentially, we are doing all we can to ensure that the patient is able to safely stay at home and not be readmitted.

Social Worker & Transportation Program

Our care coordination team includes a social worker. When a patient does not have transportation to a provider's office or cannot afford food and needs meals, for example, the social worker understands and can access the community resources available to the patient to make sure those resources are delivered.

CHESS created a transportation program a few years ago to support our traditional Medicare patients using the waivers that are available for ACOs within the CMS structure. Many of the Medicare Advantage payers have this type of model where they provide meals to a patient or provide a certain amount of transportation over the course of a year, but for traditional Medicare that is not available. Once we've exhausted other resources, we typically activate our own program to arrange transportation for the patient. We have partnered with MotivCare to deliver the service.

Pharmacy Management Program

Our pharmacy team is comprised of clinical PharmDs and pharmacy techs with several objectives for which they are responsible. First and foremost is medication adherence and medication assistance. It's a team-based effort, so we want the pharmacist working at the top of their license and the tech handling everything else. When a CHESS pharmacist engages a patient who does not appear to be adhering to a medication regimen, we look to identify the cause. Is it due to side effects, the expense, a lack of understanding, or a lack of motivation? Our team is looking to identify the drivers behind a patient's inability to adhere to the treatment regimen. Once that is identified, the pharmacy tech can begin the process of helping the patient access their medications. That means exploring options like grants, foundations, manufacturer assistance programs, or low-income subsidies.

Our team completes the paperwork and delivers it to the provider for approval. Once signed we make sure the patient's medicine is delivered to their door. Med adherence is a huge driver of our quality measures in our Medicare Advantage contracts. They are triple weighted and typically three to four of these. If you don't achieve a four-star rating on triple weighted measures, it is nearly impossible to achieve four stars in the contract.

The medication adherence measures are critically important measures to attend to and, more importantly, dramatically impact patients' quality of life and outcomes for their chronic conditions.

Value-Based Care Contracting Program

CHESS has a contracting team that negotiates value-based agreements with payers. We have value agreements in place with the major MA payers in North Carolina as well as several commercial payers. We take the negotiated value agreements to our value partners, who will execute a participation agreement to adhere to and perform according to the terms within the value-based contract.

But it's an opt-in program. They are not required to participate, but approximately 95% of the time they choose to do so because in our contracting process, our value partners are involved in the process along the way. Additionally, we involve clinicians in the contracting process. As one thinks about value-based contracting, I can't emphasize how important this is in the process.

At the end of the day, it is clinicians who do the most to deliver performance in a value-based agreement. Frontline caregivers impact clinical and financial performance, and those must coexist. So having clinicians involved early in the discussions when we negotiate a contract is very important.

Coordination & Customization with Client Teams

Our operations teams work closely with the operational leadership of our clients.

Today, of our 10 clients, nine are health systems with employed physician groups. For example, Atrium Health Wake Forest Baptist, our majority owner and our largest client, has physicians that are employed by the health system We work very closely with their physician leadership and the physicians themselves to engage in education and operationalization of the contracts. Each of our Value Partners has a master agreement with CHESS that defines not only the services we deliver, but also the services they will take ownership of to be successful in the value-based agreements they enter with CHESS.

We deliver pharmacy services to all our clients because many do not have the ability to employ a clinical pharmacist. Care coordination is different. Some of our clients we engage early in the process of developing their own care coordination programs, or perhaps they are already doing care coordination to some degree. The question then becomes, how can we build up their program? Can they come on board with our processes, and we'll support them as they build out their care coordination program?

What's the total number of FTEs do you think that are engaged in supporting these 220,000 lives, value-based care lives?

While I do not have complete insight into FTE counts within our value partners, a rough estimate would be approximately 200.

Looking at North Carolina and some of your peers looking beyond North Carolina, what's going on in the rest of the country, payers, health systems, provider groups, ACOs? Is there understanding of what needs to be built?

It varies. At least here in North Carolina, folks understand that the bulk of the FTE force that we are discussing is additive, not just repurposing existing employees. Yet, there are some exceptions.

For example, if one visits a practice versed in traditional MA, there may be an RN or two per so many providers who have some mix of those levels of skill and knowledge. I think for those folks, there is some repurposing and retraining. More importantly, it is getting the office staff to understand the model and what is being required of them. It is not just an ask of the provider, it is an ask of the entire team in the providers office.. We really need to be sure that as patients are coming for their annual wellness visit, or even for chronic care visits, we are looking and assessing where they have gaps in care. Dr. Smith does not have to be the one that closes every gap, but we ask Dr. Smith to empower her team to help. Allow the nurse, or the MA to tee up the orders for open gaps, have the provider review the orders, and sign it in the EMR and the gaps are quickly closed. That is where I see the repurposing, retraining, reeducation primarily take place. The rest of the work is additive because in the fee for service world, we are not doing that kind of work.

Another example of this is the medication adherence issue. When I was regularly seeing patients, I know there were a few times I sat in my office with a patient who was not taking their medications and were brave enough to tell me they could not afford it. More often, I knew they were not adherent based upon how their condition was being controlled. If I asked why, I knew the answer was going to be, "I can't afford it," but I didn't have a solution therefore I often did not ask Today, I help providers see that the CHESS model offers solutions. If you will refer the patient to CHESS, we will help them. You no longer have to do that. You are too busy to try to track down where Ms. Jones can go get her statin filled. If you hand that over to us, we will take care of it for you and for her.

That's the part that's additive. It was never a part of the fee-for-service model, but it does require that the work be matched to the contract. In our early days at CHESS and the Cornerstone Medical Group, we built our infrastructure for risk at a faster pace than the payers were willing to give contracts. Your contract terms and reward within the value-based agreements must match your infrastructure and capabilities. There should not be too much lag. If you get too far ahead, you are spending more than your contracts are going to return and that can lead to an unsustainable model. If you get too far behind, then you're leaving money on the table with the payers because if you're in a contract with 40% shared savings, no risk, and you're running a 77% MLR against an 82% target and you're only getting 40% of the savings , then the payer's doing fine, but you're really ready for risk and you need to take that next step.

This is why it is so important that the contracting team understands what is happening clinically, what your capabilities are, and your infrastructure capabilities, so there is nothing left on the table that should be coming to the providers.

Do you have a sense for what managing 220,000 MA lives in value-based care generates in net savings for the country, the industry, North Carolina, to offset against the added costs of those extra employees? So how much value is this aggregate value-based care program run by CHESS creating on an annual basis?

At the end of the day, on average, our more mature clients in risk based agreements are seeing, on average, a three to one return on their investment.

So, for every $1 million of additive costs - that includes all the additive expenses we have discussed - the health system partner is seeing about $3 million in net earnings.

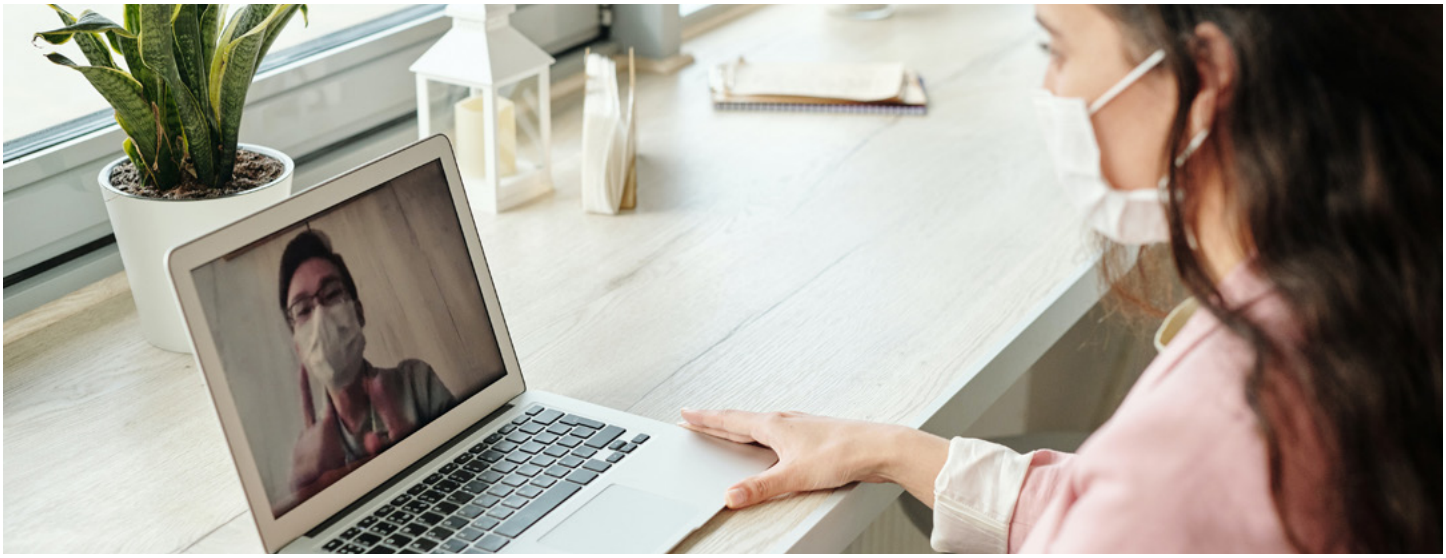
Because in some ways a MCR ACO has been competing against itself year over year, there's a point of diminishing returns. A lot of folks have gotten out of Medicare ACOs. We have seen the number of folks participating in the Medicare ACOs drop over the last few years. CMS has made some adjustments and the methodology looks better which I think will help bring folks back in, but I don't know that I can give you numbers nationally.

It does suggest that these rising thresholds are rising awfully quickly and so the government is incentivizing a lot of value-based care activity, but not incentivizing very well the continuity of that. So that's certainly problematic. I mean, if you play that out to its fullest extent without meaningful change, there's going to be a lot of pain out there.

What advice would you give that national value-based care operators as someone who by contrast has focused on building a large VBC platform in one state?

I think CHESS has benefited from working with our value partners to take a broader population approach. When you look at Oak Street, Privia, Village MDs, Iora/One Medical and others that you mentioned, they often tend to come in and segment populations, whether they're a full-on clinic model, like I think Iora is, or more of an enablement solution like Privia. Comparatively, CHESS has taken on a broader population approach. What I mean by that is, not just focus on traditional Medicare - we have Medicare, Medicare Advantage and commercial contracts. If you are an enablement company, I think you end up with this scenario: "Oh, I have to talk to these folks about Medicare and these folks about Medicaid, and these folks about my commercial populations, and oh, by the way, we have a direct employer offering over here." Physicians get multiple patients, and service providers coming at them representing totally different lines of business, which is very frustrating for them.

We have learned that lesson, especially working with Wake Forest. As an academic medical center/safety net hospital, Wake Forest takes all comers. The way they think about it is that they are at risk for the uninsured. Because of that, they have had to consider which of these programs to put in place for our uninsured population to reduce over-utilization of the emergency department or the inpatient setting. I think if you're one of the entities you named, you're less likely to think that way. So, your community benefit is diminished, whereas in the academic medical center, it's supported through these models. The focus needs to be on physician engagement and community involvement. I worry about two things with these models. One is the entities are coming in and starting new practices, and if they're an Iora/One Medical for instance, and they are only seeing Medicare Advantage patients, then because of the way these models are set up and the premium dollar is driven by RAF coding, they want the sickest of the sick and they spend lots of time with these patients and put many resources around them. While that may set up a successful financial model, you are hurting the folks in the academic medical center.



So you can actually damage the work that's already happening in a community setting. These groups do present a real challenge to the traditional health system practice model with their open access philosophy. Access is a cornerstone of these programs. If there were only one lever I could pull in a primary care practice it would be to create open access. Open access will do more to keep patients who do not need to be there out of the acute care setting.

Sometimes we are a victim of our own problems in that we do not create access for patients in value-based agreements, therefore the competition comes in, sets up access, and skims off patients.

One advantage I think we have enjoyed, because we have a health system investor, is a different expectation in terms of the return. When think back to the previous question and our conversation about the law of diminishing returns, I worry about what it is going to look like in 10 or 20 years. If the expectation is continued high returns, I do not know how that is sustainable. At the end of the day, if you invest money into a that model and expecting a certain return, how quickly is that return going to happen and if it diminishes over time what exactly are we all going to be left with?

What do you think of the super practices versus the hospitals? And I'm just curious if you had been exposed to them or thought about how you might plug into the super practice world if that was something you were interested in.

I believe that the super practices will continue to grow. I think physicians are tired. They were burned out before COVID, and even more so now. There are a lot of independents, and I would say probably the majority of independents remain independent and do not want to be employed by a health system. The super practices sometimes offer physicians 10 to 20 year agreements in some cases. My concern is there is no way to predict how things will be in 10 years. We are not sure what things are going to look like in five years. I worry about what physicians are signing up for, but I think that is going to continue. There will be pockets of success where health systems get on board, pool their providers, and successfully figure out ways to engage independent providers without having to employ them. You can look out west at Intermountain Healthcare in Utah, in an agreement with Castell Health, and they have been at this a long time. They have morphed their model, but are doing some really creative things. However, I tend to agree with you that for now I see the super practice as a kind of juggernaut.

How do you think about controlling and maintaining margins. It seems like there's a potentially never-ending need and opportunity to build infrastructure, and you mentioned about aligning payer contract structure with that infrastructure investment. Is there any insight you can offer us in terms of strategies for managing margins in that context and whether this has been a challenge? How do you see that playing out for service providers or intermediaries in the market that are responsible for a heavy lift in terms of building infrastructure and face pressure from both the provider and payer sides to further invest / build and deliver results?

It is maximizing performance within a contract with existing resources. At CHESS we are constantly asking "how can we use what we have to leverage a higher star rating, a lower inpatient rating, et cetera? But it is also, thinking deeply about better efficiency. I know that artificial intelligence and machine learning gets a lot of attention and I certainly don't think it is absolute solution to our problems, but in many ways I think, as an industry, we have taken a blanket approach to population health - touching every single patient that gets discharged from the hospital for a TCM call and visit. Maybe they don't all need that outreach. Can I get to a place where I know which patients to touch and in what order? That that's just one narrow example.

Also, getting more into predictive analytics and then into more prescriptive analytics. So not only do I know who to touch and when, but I also know what to do for that patient to give us the highest opportunity for a better outcome. I'm not suggesting that is free, but the next slice of the pie at driving and improving margins is going to be in that predictive, prescriptive analytics bucket and more efficiently engaging patients. This patient should have an in-home visit, this patient just needs a text, and if I can begin to sort my populations that way, then I can drive efficiency and free up some time of folks calling patients that only need a text, and call more of the people that need to be called.

Can you speak about areas of the healthcare delivery ecosystem that you're focused on versus less focused on – for example, how deep do you get into specialty care?

In the last few years we have not been heavily engaged with specialists. We are working closely with a new partner, a group of primary care physicians, to create specialty models. That will connect primary care and a specialty group. Take orthopedics, for example. This group has a low back pain program, and a physical therapist embedded in their office. For patients with a new diagnosis of uncomplicated low back pain, they see the physical therapist in the primary care office first before there's ever an orthopedic referral. The goal is to get to those cost management programs that identify a population of patients or a specialty. We could think about congestive heart failure the same way. How do we approach that group of patients and begin to work with cardiology to build programs that will manage cost on almost a bundle basis?

If you met yourself in 2011, what advice would you give yourself having learned everything you've learned over the last 10 years?

Learn to embrace complexity and lean into it. It's okay. You don't have to have all the answers. As a physician, I want all the answers, and I'm supposed to be the expert on everything. I don't have to be, put a good team around you.

Special thanks to Yates Lennon, MD, MMM, for his insights in this discussion.