Panel Discussion 1: *Strengthening Advanced Primary Care and Improving Specialty Integration*

Panelists:

Subject Matter Experts

- **Ann Greiner, MCP**, President and Chief Executive Officer, Primary Care Collaborative
- **Paul Casale, MD, MPH**, Vice President, Population Health, NewYork-Presbyterian, Weill Cornell Medicine and Columbia University
- **Adam Weinstein, MD**, Chief Medical Information Officer, DaVita Kidney Care

Care activities and relationships in Value-Based Kidney Care Programs

Observations and Thoughts from the Renal Physicians Association

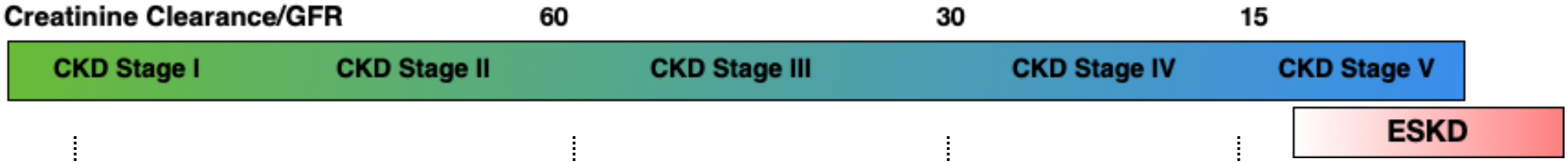
Adam Weinstein, MD

Prepared for the Physician-Focused Payment Model Technical Advisory Committee (PTAC)

March 2, 2022

The Renal Physicians Association (RPA) is the advocacy organization of nephrology professionals in their pursuit and delivery of quality kidney care.
www.renalmd.org

Ideal Kidney Disease Management



Jobs to be Done	• Identify high-risk populations • Modify risk factors	• Modify risk factors • Slow CKD progression • Treat complications	Ongoing Care, Plus: • Transplant Prep • Dialysis Prep • QOL discussions	+ optimal start + home dialysis + transplant + EOL Discussions
Accountable Provider	Primary Care	Primary +/- Nephrologist	Nephrologist	Nephrologist
Associated Providers	Nephrology, Endocrine, Cardiology	Primary Care, Endocrine, Cardiology, Dieticians, and Kidney Educators, and Kidney Care Organizations	Previous + vascular surgeons, and transplant centers	All Previous

CKD = Chronic Kidney Disease; ESKD = End-stage Kidney Disease

Considerations in Value-Based Kidney Care Relationships

Consideration	Description
Geography	Urban, suburban, and rural communities all have unique challenges – programs should respect the state and regional variations
Workforce	Programs should anticipate the constrained availability of chronic disease-focused physicians and advanced practitioners in most communities (endo, rheum, neph, cardiology, etc.)
Tech/Data	Despite evolving interoperability, key data is often not discrete (e.g. labs), and data volume is massive. Timelines to integration are long and expensive.
Practice Proficiency	Specialty practices are not typically optimized for population health, and practice transformation can be highly variable, even within a practice.
Safe Harbors	Patient care spans multiple organizations and care providers. VBC programs must have clear and broad safe harbors to allow the various community actors to appropriately align resources in delivering comprehensive care.

Thank you

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Appendix Slides

Reference: Kidney Disease Vocabulary

Acronym or Shortened Phrase	Expanded Form	Definition in this Presentation
CKD	Chronic Kidney Disease	Diminished kidney function as measured by eGFR (estimated glomerular filtration rate) – a calculation based on age, gender, and serum creatinine. Education, risk factor modification, and patient engagement are key associated services.
ESRD or ESKD	End-stage renal or kidney disease	The physiologic state in which a patient's kidneys no longer function well enough to sustain them. These patients require dialysis or transplant to remain alive.
Optimal Start	Optimal Dialysis Start	Initiating a patient on dialysis in an outpatient setting on either peritoneal dialysis or on hemodialysis without a central venous catheter
QOL/EOL Discussions	Quality of Life and End of Life	Discussions with a patient about expected functional status, health and life goals, and length of life
CKD Education	Chronic Kidney Disease Education	Educating a patient about the various options available for managing end-stage kidney disease and necessary diet and risk factor modification. Promotes optimal starts, home dialysis, and transplant preparation
Kidney Care Companies	Value-based kidney care companies that may offer dialysis services	Companies accepting financial risk for co-managing (with nephrologists) patients with kidney disease. They offer a range of care coordination services and may also provide dialysis.

Successful Roles in Renal Value-Based Care

Ideal:	Nephrologists and Neph Practices	Kidney Care Organizations	Health Systems and Payers	Patients and Care Providers
Clinical Actions	Provides direct patient care decisions and leads pop health decisions	Provides at-scale care coordination, technical, and logistics support	Provides data and *some* care, logistics, and care coordination	Open to communication, education, and engagement
Admin Role	Receives IT, gathers data, and front-line administrative direction	Provides IT, analytics, and administrative support	Provides data, ADT notifications, and partnership	Vocal about needs and advocacy
Features	• Meaningful eward • Moderate Risk • Minimal up-front investment • Simplified reporting and accountability burdens	• Meaningful Reward • Meaningful Risk • Larger initial and on-going investment • Time for contract and IT development	• Some Reward • Limited additional risk • Minimal investment • *Interoperability is critical*	• Understands the benefits of participating • Experiences minimal disruptions to care relationships

Typical Timelines in Kidney Disease Value-Based Care

Action	Timeline/Examples
Aggregating and signing agreements between practices, kidney care organizations and related providers	• 2-6 months for negotiations and agreement signing
IT software development	• 6-12 months for minimally viable product from program detail finalization and defining requirements • Ongoing refinement to meet specific workflows and functionality
Patient engagement	• Typically, weeks to months to engage patients in program enrollment and consent
High Risk Patient Identification	• Various lab-data and claims-based risk formulas can estimate risk of progression to ESKD between 12 months and 5 years into the future. Optimal care may not result in a measurable change in an individual patient during a single calendar year.
Measurable outcomes	• Both process and outcomes must be considered to capture the impact of care given prolonged timelines to ESKD

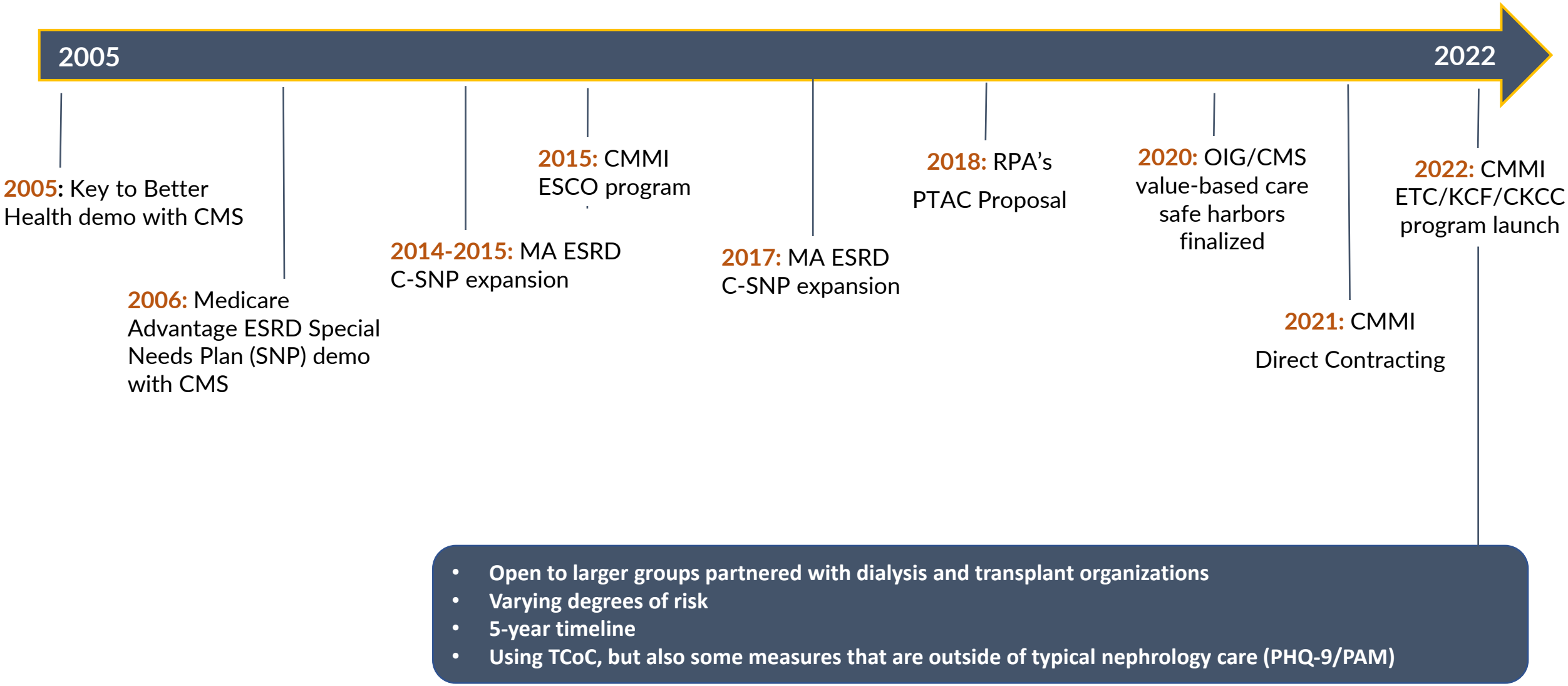
Kidney Disease Works Well as a TCoC Model

Points of Alignment	Examples
Significant financial savings opportunities	• $100K/yr for dialysis vs. $15K/yr for transplant (after $150K in year 1) • Dialysis w/ an optimal Start is ~$30K less costly than unplanned dialysis
Highly prevalent disease state	• 30-40 million individuals with CKD/ESKD
Long lead time	• Typically, years from CKD to ESKD
Well defined patient population	• Quantitative, simple, and validated measurement of disease state (eGFR) • A clear set of CPT-labeled services and ICD-10 codes (stages of CKD)
Measurable and cost-effective treatments/outcomes	- Risk Factor Modification - Transplant - Dialysis Education/Preparation - Palliative Care
Reasonable attribution	• Attribution through claims • Claims can be used to identify associated services and the timing of services • Reasonably accurate day and physician for dialysis initiation data (2728 form)

Ideal Components of a Kidney Disease Payment Model

Actor	Idealized Goal or Characteristic
CMS/Payers	• Improve outcomes in kidney patients; increase home dialysis and transplant rates • Reduce costs of caring for kidney patients
Patients *and Care Givers*	• Incentivize to participate and engage in the program • Address regional and local healthcare disparities (transportation, food, access to care, etc.)
Nephrologists/Providers	• Allow for time to transform/adapt work to non-FFS care delivery • Reward processes AND outcomes of care – measures specific to kidney disease • Achievable quality benchmarks and moderate discounts to attract broader participation • Quality bonuses for addressing healthcare disparities
Nephrology Practices	• Allow time, resources, and personnel to embrace data-driven and non-RVU care • Allow time to partner with other providers • Flexible risk-sharing opportunities
Kidney Care Companies	• Reward process and outcome of value-based arrangement performance • Safe harbors to partner with referral sources and offer variable shared-risk • Time to develop data tools and interoperability
Other Specialties and Health Systems	• Safe harbors to improve focus on the subset of kidney-specific procedures and patients • Resources to incent participation

17 Years of Value-Based Care Programs for Patients with Kidney Disease



Panel Discussion 2: *ACO Perspectives on Specialty Integration and Improving Care Delivery*

Panelists:

Subject Matter Experts

- **Emily Brower, MBA**, Senior Vice President, Clinical Integration and Physician Services, Trinity Health
- **Cheryl Lulias, MPA**, President and Chief Executive Officer, Medical Home Network (MHN)
- **Emily Maxson, MD**, Chief Medical Officer, Aledade

Trinity Health

Integrating Episodic or Specialty Payment Models with Population-based Payment Models

Emily Brower
Trinity Health

PTAC Public Meeting
March 2, 2023

Our **Mission**

We, Trinity Health, serve together in the spirit of the Gospel as a **compassionate and transforming healing presence** within our communities.

Our **Vision**

As a mission-driven innovative health organization, we will become **the national leader in improving the health of our communities and each person we serve**. We will be the **most trusted health partner for life**.

Our **Core Values**

Reverence

Commitment to Those Who are Poor

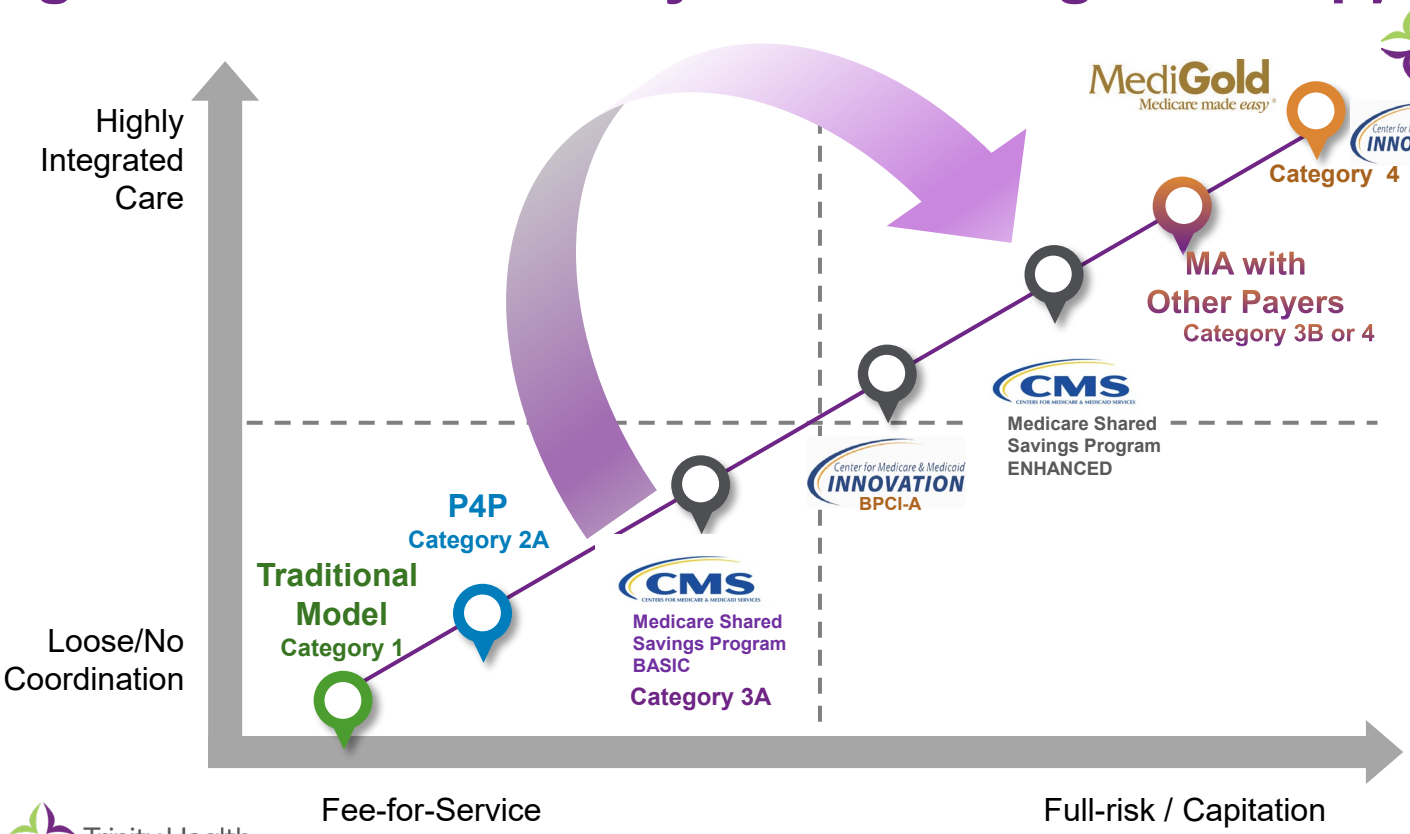
Safety

Justice

Stewardship

Integrity

We have advanced our APM strategy over time to take on greater accountability and create greater opportunity



Category 1
Fee for Service – No Link to Quality & Value

Category 2
Fee for Service – Link to Quality & Value

Category 3
APMs Built on – Fee-for-Service Architecture

Category 4
Population-Based Payment

Trinity Health

We currently hold $10.9B in cost of care accountability for 2.0M people

	Annual Medical Cost	Attributed Lives
Medicare ACOs	$3.2 Billion	297,000
Medicare Advantage	$2.1 Billion	183,000
PACE / LIFE	$350 Million	3,300
Bundled Payment for Care Improvement Advanced	$210 Million	12,700
Colleague Health Plan*	$1.1 Billion	155,000
Commercial & Medicaid	$3.3 Billion	850,000
Maryland All-Payer Global Budget	$630 Million	488,000

Trinity Health

*Colleague health plan is total medical and Rx cost, not adjusted for domestic or colleague payroll contributions. Data as of 6/30/2022.

We see advantages in Aligning and Integrating Episodic and Specialty Models

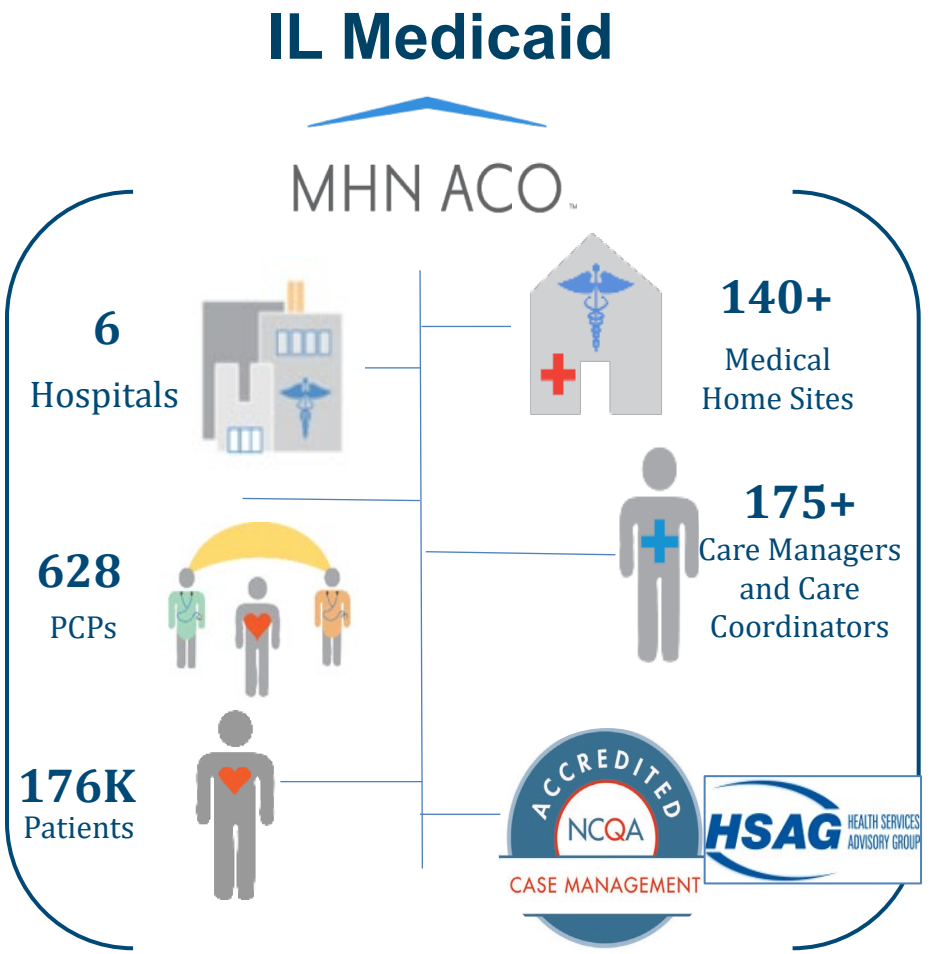
- Trinity Health **has participated broadly** in both episodic and total cost of care models, mostly **nesting episodic** models **inside total cost of care**.
- Participating in bundles gives us **focused opportunity** to improve care during a **critical period for patients**, and extend accountability beyond primary care.
- Coordination is vastly improved because there is **one process**, one team navigating care, insight into all the needs within the population.
- Even with low volume, we find it **worthwhile to invest** the time and resources necessary to participate, and may choose episodes even where there is little pricing opportunity in the episode, but is savings opportunity in total cost of care
- **Participating in both offsets disincentives** for including specialists in ACOs today (AAPM Qualifying Participant threshold calculation, high/low revenue distinction)
- No matter where the savings are earned, they are retained by Trinity Health, supporting broad investment in population health and **reducing overlap** concerns.

Cheryl Lulias
President and CEO
Medical Home Network

MEDICAL HOME NETWORK

Medical Home Network (MHN):Transforming Care and Improving the Health of Safety Net Communities

- **13 FQHCs & 3 Hospital systems**
- **176K IL Medicaid Members in a Global Risk Arrangement**
- **50K MHN ACO REACH Individuals Attributed to FQHCs across 7 States**
- **Delegated for Care Management**
- **NCQA Accredited for Case Management**
- **Integrated Practice-level Care Teams**
- **Specialized Care Coordination Certification Program**



MHN: Managing Complex Members with a Driving Behavioral Health Diagnosis

Days Post-Admission	1-30	31-60	61-90	91-120	121-150	151-180
Number of Eligible Individuals	699	667	648	635	613	597
Claims Category	Percent With	Percent With	Percent With	Percent With	Percent With	Percent With
Total	**86.7%**	**78.4%**	**78.1%**	**75.7%**	**73.7%**	**72.0%**
Rx-Psych/Sub	50.5%	43.9%	45.1%	38.7%	40.8%	39.4%
Rx-Other	54.6%	46.3%	46.0%	44.7%	43.7%	46.2%
Ambulatory-Psych/Sub	64.5%	54.0%	52.3%	49.4%	48.0%	45.2%
Ambulatory-Other	52.4%	45.9%	44.9%	42.5%	43.1%	40.5%
Ambulatory-Primary Care	40.3%	27.6%	30.1%	25.7%	26.9%	27.5%
ED-Psych/Sub	13.9%	10.8%	12.8%	9.4%	10.9%	8.2%
ED-Other	20.2%	16.0%	15.6%	15.4%	15.0%	16.1%
Inpatient-Psych/Sub	16.3%	11.8%	15.7%	12.1%	14.2%	10.6%
Inpatient-Other	2.9%	2.5%	2.0%	3.6%	2.1%	3.0%

MHN: Managing Complex Members with a Driving Behavioral Health Diagnosis

Days Post-Admission	0-30	31-60	61-90	91-120	121-150	151-180	331-360
Number of Individuals	702	640	596	543	500	452	309
Total Cost of Care	Avg Paid	Avg Paid	Avg Paid	Avg Paid	Avg Paid	Avg Paid	Avg Paid
Psychiatric High	$1,679	$1,740	$1,234	$848	$1,258	$1,199	$1,260
Psychiatric Medium	$2,232	$1,676	$1,403	$1,735	$901	$1,112	$1,778
Psychiatric Medium-Low	$1,178	$871	$782	$553	$1,040	$650	$666
Psychiatric Low	$1,340	$821	$547	$589	$754	$740	$29
Substance Abuse Low	$1,254	$1,085	$1,457	$1,117	$1,693	$1,498	$246
Substance Abuse Very Low	$2,556	$1,806	$1,868	$2,513	$1,675	$2,244	$2,094
Total	$1,495	$1,182	$1,120	$995	$1,201	$1,050	$1,058

MEDICAL HOME NETWORK

MHN: Behavioral Health Mobile Crisis Team (BHMCT) Program

BHMCT is a partnership between MHN primary care medical homes and **a community mental health center (HRDI)** focused on addressing the complex needs of MHN ACO patients who have been identified as needing a high level of care management to prevent rehospitalizations.

Intensive Care Management Provided by BHMCT Includes:

- Meeting with patients face to face while hospitalized and for post discharge case management meetings
- Communication & collaboration with medical home care teams and MHN Transition of Care team
- Coordination of community-based resources to address social drivers of health such and shelter and food
- Providing specific BH supports to be stabilized in the community such as med adherence, escort to appointments, working with any caregivers, etc.

BHMCT Process

Behavioral Health Hospitalization occurs

HRDI Engages with patient while in the emergency room or inpatient setting to oversee a safe discharge

HRDI continues to provide intensive BH case management

Medical Home Collaborates with HRDI on a weekly basis

Patient is stabilized in the community and care is transferred Medical Home

MEDICAL HOME NETWORK

MHN: Early Successes of Behavioral Health Mobile Crisis Team

Medication Adherence

40% Target Met! **63.2%**

Patients were adherent to their antidepressants

50% Target Met! **64.4%**

Patients were adherent to their antipsychotics

Initiation of treatment within 14 days of hospitalization

51% Target Met! **62.5%**

Patients with a primary diagnosis of SUD that initiated treatment within 14 days after hospitalization

Ambulatory visit with a behavioral health provider

65% Target Met! **71.3%**

Patients had a visit with a BH provider in any given month in the 6-month post-hospital discharge period

Readmission rate for enrolled population

<20% Target Met! **20.8%**

Reduced 30-day readmission rate for BHMCT patients during enrollment

- BH 30-day readmission rate pre-enrollment: 87.6%
- Average Length of Stay decreased across all causes

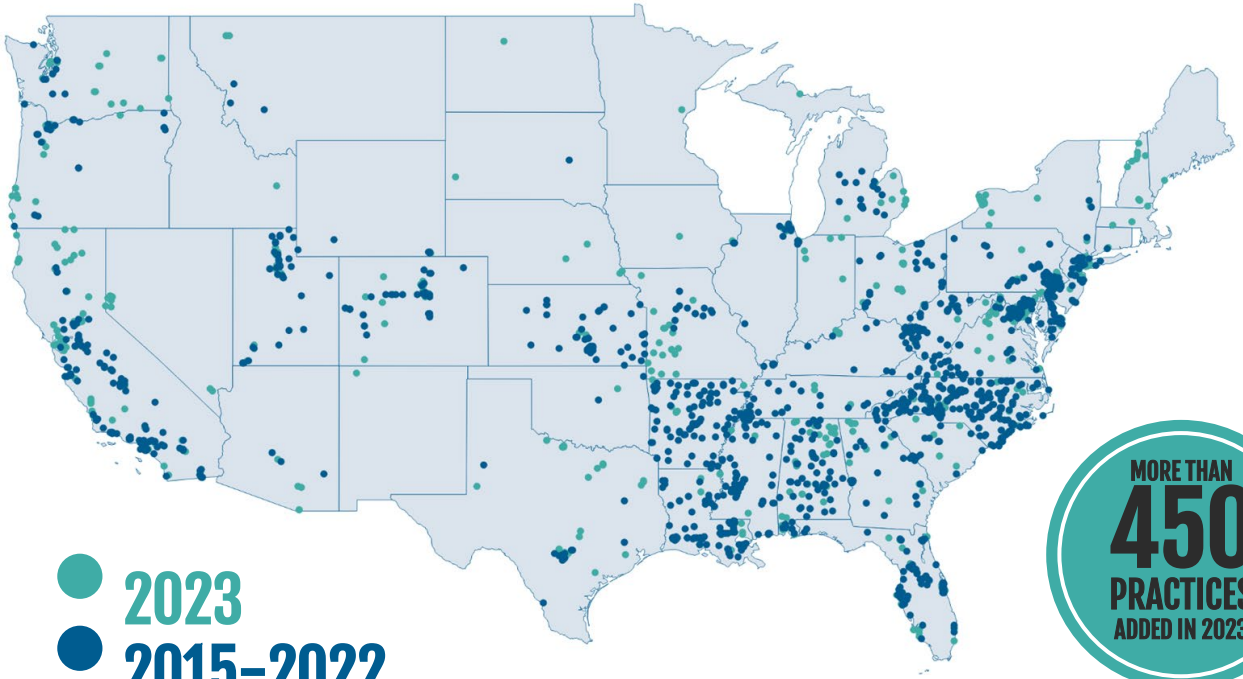
MEDICAL HOME NETWORK

PTAC Total Cost of Care

Dr. Emily Maxson
Chief Medical Officer
Aledade

March 2, 2023 Public Meeting
Panel Discussion

The **largest** independent primary care network in the country.



MORE THAN **450** PRACTICES ADDED IN 2023

NETWORK

5,000+ PCPs
1,500+ PRACTICES

SCALE

2M+ LIVES
145+ VALUE-BASED CONTRACTS
$20B+ MEDICAL SPEND

RESULTS

$450M+ '22 REVENUE
$135M+ '22 PLATFORM CONTRIBUTION
EBITDA POSITIVE SINCE 2020

Aledade analysis of internal data; MSSP-only practice & ACO data available at https://data.cms.gov/medicare-shared-savings-program. 2022 results are unaudited.

2

Aledade has explored various dimensions of Specialty Care VBC Integration over the past 8 years.

Key Insights:

- It is very difficult to change a primary care clinician's referral patterns in an open network
- Clinicians were highly satisfied with E-Consults (3 different vendor pilots) - but rarely used them
- Highly targeted third party interventions performed in collaboration with the primary care practice show great promise
- Inviting a specialist into a primary care ACO can bring attribution without end-to-end accountability
- Partnering with an external entity in a shared risk arrangement requires up front understanding of cost accountability

3

Thank you.