

# Physician-Focused Payment Model Technical Advisory Committee

## Panel Discussion: *Providing Patient-Centered Care for Patients with Complex Chronic Conditions or Serious Illnesses in PB-TCOC Models*

### Panelists:

#### *Subject Matter Experts*

- [Erik Johnson, MBA](#) – Senior Vice President, Value-Based Care, Optum Advisory
- [Richard A. Feifer, MD, MPH](#) – Chief Medical Officer, InnovAge
- [Kristofer L. Smith, MD, MPP](#) – Chief Medical Officer, Landmark Health
- [Marshall H. Chin, MD, MPH](#) – Richard Parrillo Family Distinguished Service Professor of Healthcare Ethics, Department of Medicine, University of Chicago, and Co-Director, Robert Wood Johnson Foundation Advancing Health Equity Program Office

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**Erik Johnson, MBA**

Senior Vice President, Value-Based Care  
Optum Advisory

# Introductions

## Erik Johnson, SVP and National Practice Lead for Value-Based Care and Population Health

We focus our practice on assisting payers and providers in developing value-based contracting arrangements that delegate risk to providers; enhance benefit design to optimize member access to benefits; and put in place sustainable population health and care management models to manage the care of poly-chronic and rising risk populations.

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## Optum Advisory Services

Optum Advisory Services is a consultancy of over 2,000 consultants focusing on every aspect of the health care continuum, in every type of insurance model, and backed by industry leading analytics.

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## Our Perspective

Improved clinical and financial outcomes necessitates moving decision making as close to the point of patient care as possible to provide timely, informed, and effective care interventions. Improved clinical models must be accompanied with meaningful improvements in data at the point of care and substantial financial incentives to allow providers to recapture the value they create for the health care system.



**Erik Johnson**

*Senior Vice President, Optum  
Advisory Services*

# Key Takeaways: Managing Complex Chronic Conditions and Serious Illness



## Consistent risk stratification based on diagnoses and symptoms

- Target populations as prioritized by risk factors, common conditions, and utilization patterns
- Assist with defining care team roles across the enterprise to match population needs.

## Treat the individual in their environment

- Promote top-of-license and team-based care.
- Document and address environmental and social determinants of health; document and design care around any emergent functional limitations on activities of daily living
- Involve family members/caregivers in the design and delivery of care where possible

## Minimize and eliminate sources of abrasion with the system

- Same day access to members of the care team
- Steady cadence of care team outreach to patient/family members, with focus on medication reconciliation/refill, access measures (e.g., transportation) and navigation to network participants

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**Richard A. Feifer, MD, MPH**

Chief Medical Officer, InnovAge

# Richard Feifer, MD, MPH, FACP

## Chief Medical Officer, InnovAge

### InnovAge Overview

- **PACE Provider/Payer**
  - Comprehensive, personalized, interdisciplinary care for high-cost dual-eligibles, who meet state eligibility criteria for nursing home placement
    - Average RAF 2.47
    - >10 touchpoints and 4 center visits per month
    - Concierge-like PCP model (3-7 visits/day)
  - Keeping people living independently as long and as safely possible
  - Medicare Part C and Medicaid capitation (including the cost of long-term care)
- **InnovAge Scale**
  - 20 Centers in 6 States
  - ~6,820 participants and ~2,100 staff\*

### Personal Background

- **InnovAge (2022-present)**
  - Primary care, nursing, dentistry, behavioral health, pharmacy, home health, population health, utilization management, case management, quality, clinical analytics, network management, coding
- **Genesis HealthCare (2016-2022)**
  - Largest operator of SNFs and LTC facilities, over 400 centers in over 25 states
  - CMO and President of Genesis Physician Services
  - Launched LTC ACO, the first national MSSP ACO focused on nursing home patients

# Opportunities for Improving Care

- **High Value Care Delivery Approaches**

- Interprofessional care planning that is fully aligned
- Goals-of-care and advance care planning
- Integrated end-of-life and palliative care
- Holistic (versus disease centric) care
- ER diversion
- High-performance NF/ALF\* network
- Addressing SDOH

- **Important Watch-Outs**

- Polypharmacy
- Inappropriate cancer screening
- Part D pharmacy coverage

\* Nursing facility / assisted living facility (NF/ALF)

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**Kristofer L. Smith, MD, MPP**

Chief Medical Officer, Landmark Health



# Kristofer Smith, MD, MPP

## Chief Medical Officer, Optum at Home Optum Home and Community Care

### Current role

- CMO for a large risk bearing entity that is clinically and financially responsible for 1.15M Dual Eligible Special Needs Plan (DSNP) and 600k Medicare Advantage lives
- Provide Home-based medical care for >150k patients
- Provide care management services for >500k patients
- 35 states and >3000 clinicians

### Organizational Reach

- Home and Community Care is a comprehensive risk bearing platform that includes naviHealth, Landmark, HouseCalls, Senior Community Care, and Optum at Home
- >13M patient interactions in 2023
- 50 state footprint
- 17,000 employees
- >\$30B in medical spend under management

### Experience

- Internal Medicine and Palliative Care boarded
- 11 years providing primary and palliative care at home
- 15 years of population health experience in the payer, provider and disrupter space
- Built programs for bundled payments, readmissions reduction, collaborative care, practice-based care management, community based high risk Medicaid, home-based medical care, HEDIS/STAR, documentation, payment integrity, and affordability

# Effective Care Delivery Approaches for High-Cost Patients with Complex Chronic Conditions

## Key Learnings

- Patients with complex chronic conditions are not all persistently high cost
- Patients with complex chronic conditions that are persistently high cost typically have a multiple substantial conditions
- Given the first two points, disease management programs typically fail to sustainably reduce cost and improve outcomes, so comprehensive programs are needed
- There are reactive and proactive aspects to successful models for persistently high cost, complex patients
  - To be successful, reactively, patients or caregivers must reach out to the program when clinical conditions deteriorate
  - To get a patient or caregiver to reach out, the program, when contacted, must provide a meaningful response in a timely manner, as determined by the patient, not the program.
  - To be successful, proactively, patient clinical and non-clinical needs must be identified and managed according to best available practice and evidence
  - In order to provide evidence-based care high quality clinicians, managers, platforms, and protocols are needed
- Financial reconciliations continue to have too much uncertainty and inconsistency for complex care models to thrive

# Effective Care Delivery Approaches for High-Cost Patients with Complex Chronic Conditions

## Key Mistakes

- The tyranny of the easy-to-implement, the trap of top-of-license, and the siren song of efficiency
- Scaling too fast
- Saying culture is important but not living it in decision making

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**Marshall H. Chin, MD, MPH**

Richard Parrillo Family Distinguished Service Professor of Healthcare Ethics,  
Department of Medicine, University of Chicago, and  
Co-Director, Robert Wood Johnson Foundation  
Advancing Health Equity Program Office

# Marshall Chin, MD, MPH

- Richard Parrillo Family Distinguished Service Professor of Healthcare Ethics, University of Chicago
- Co-Director, RWJF Advancing Health Equity: Leading Care, Payment, and Systems Transformation
- Co-Chair, CMS Health Care Payment Learning and Action Network Health Equity Advisory Team
- Expertise: Aligning payment and care transformation across stakeholders to advance health equity, within anti-racist culture of equity

# Overview of Key Takeaways

- Literature review of equitable interventions: Holistically address medical and social needs; effective communication and strong relationships with patients; close follow-up and monitoring of patients; team-based care; cultural tailoring; families; communities
- Intentionally design to advance health equity
- Payment and accountability metrics should support and incentivize intended care transformations – align with social return on investment and interventions addressing health care equity, health-related social needs, & structural social drivers of health; no “magic carpet” thinking
- Creating a culture of equity is equally as important as technical aspects for sustainable change at scale

# Appendix

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