

Clinical Integration within your ACO/CIN: Managing the Challenges of Keepage and Leakage

NAACOS Fall Conference

Friday October 1, 2021, 11:45-1:15PM

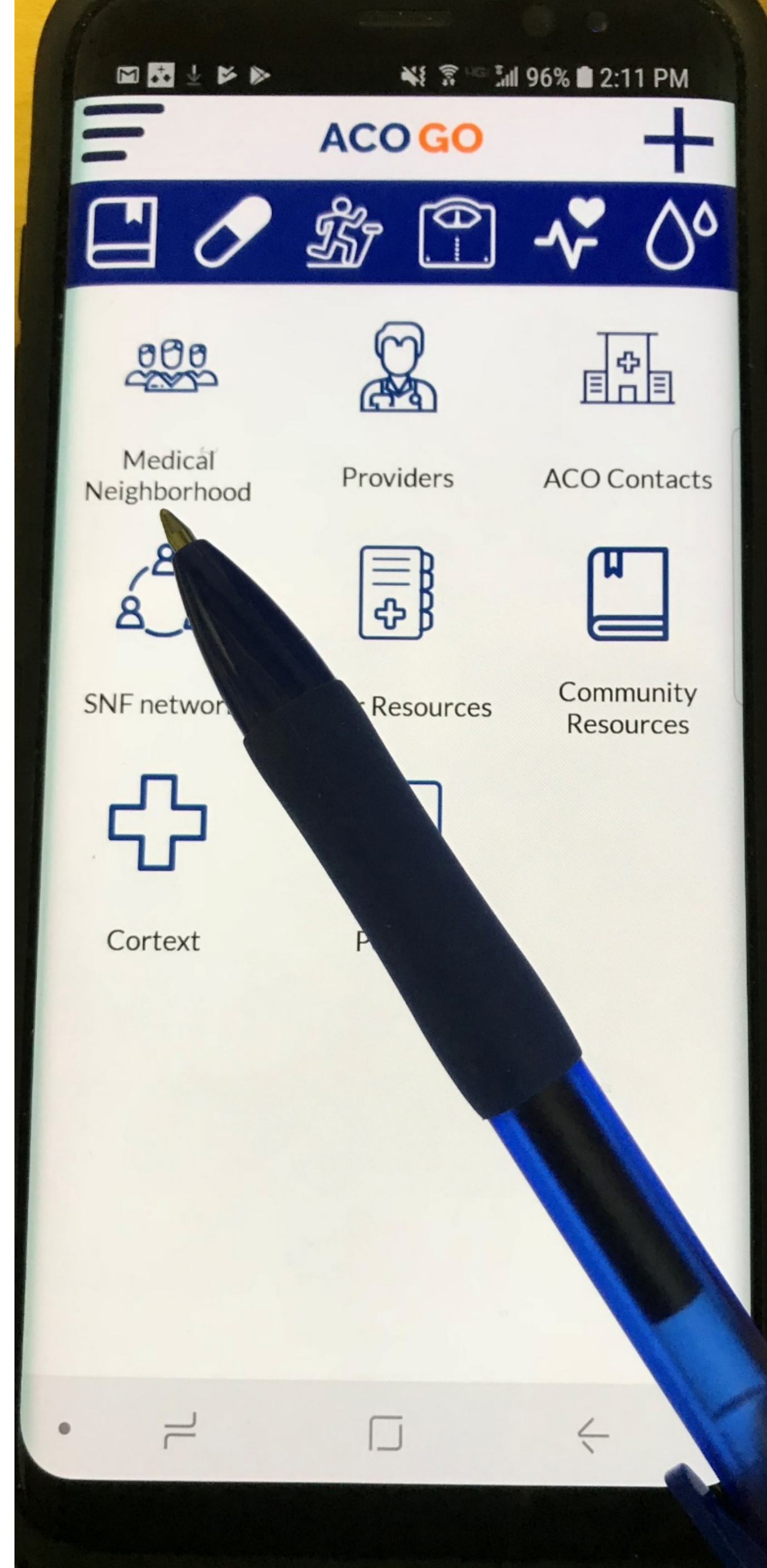
➤ Panelists:

- Tom Kloos, MD, Panel Moderator (Thomas.kloos@atlantichhealth.org)
 - Past Chair, NAACOS President Atlantic ACO, VP AHS, New Jersey
- Heather O'Toole MD (hotoole@icphealth.com)
 - Chief Medical Officer, Innovation Health Partners, Scottsdale Arizona
- Jack Cappitelli MD (jcappitelli@summithealth.com)
 - Chief Medical Officer, Summit Health –New Jersey Region
- Jim Barr, MD (james.barr@atlantichhealth.org)
 - VP Physician Value-Based Programs, CMO Atlantic and Optimus ACOs , New Jersey
- Kimberly Busenbark CEO Wilems Resource Group
(kwilems@wilemsrg.com)

Agenda

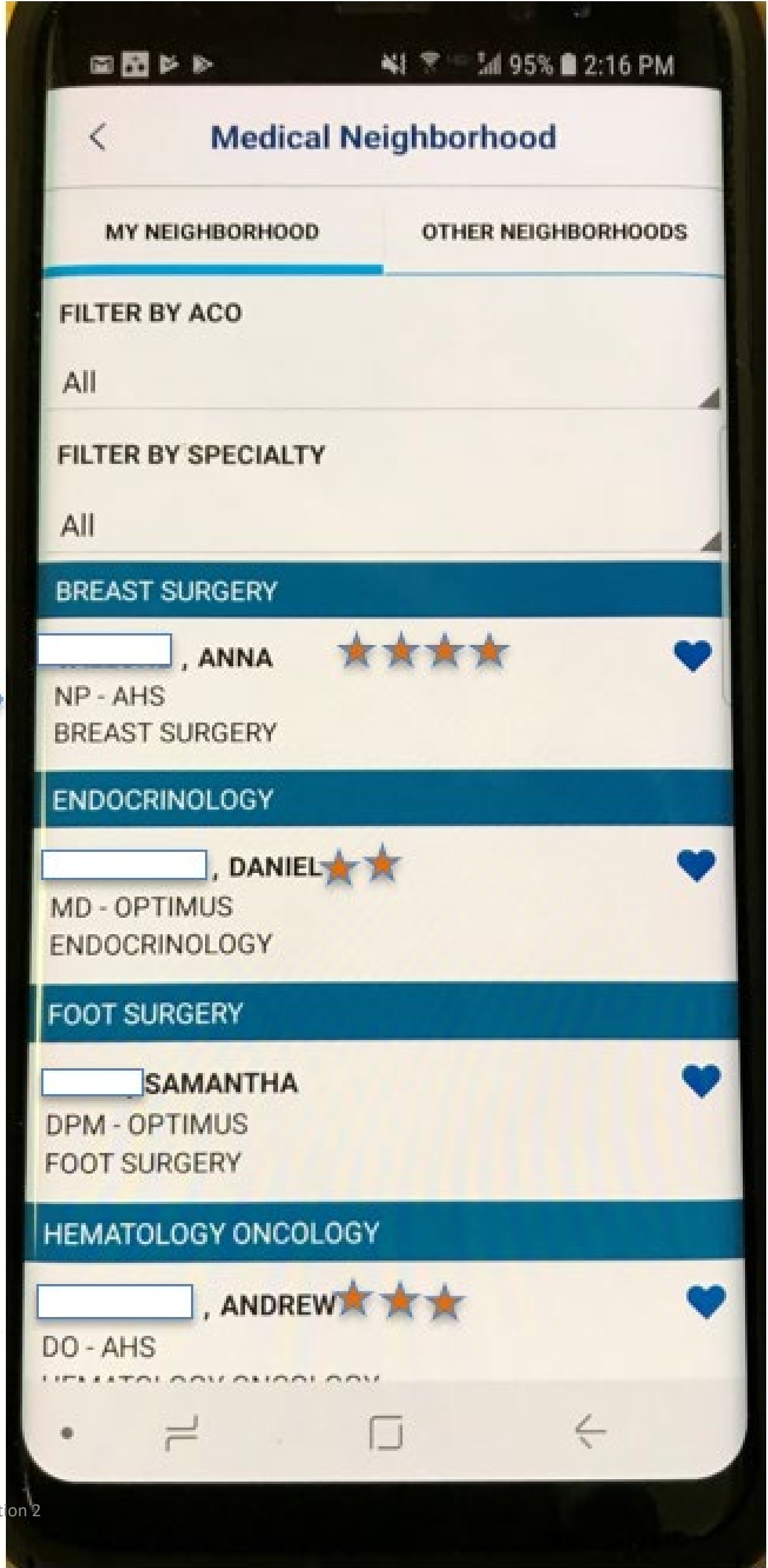
- Introduction to Topic
 - The Innovation Care Partners Experience
 - The Summit Health Experience
 - Clinical Integration Data Analytics
 - The Compliance of Incentivizing Clinical Integration
 - Questions and Discussion
- Tom Kloos
Heather O'Toole
Jack Cappitelli
Jim Barr
Kim Busenbark

ACO-GO
Medical
Neighborhood
Functionality



ACO-GO

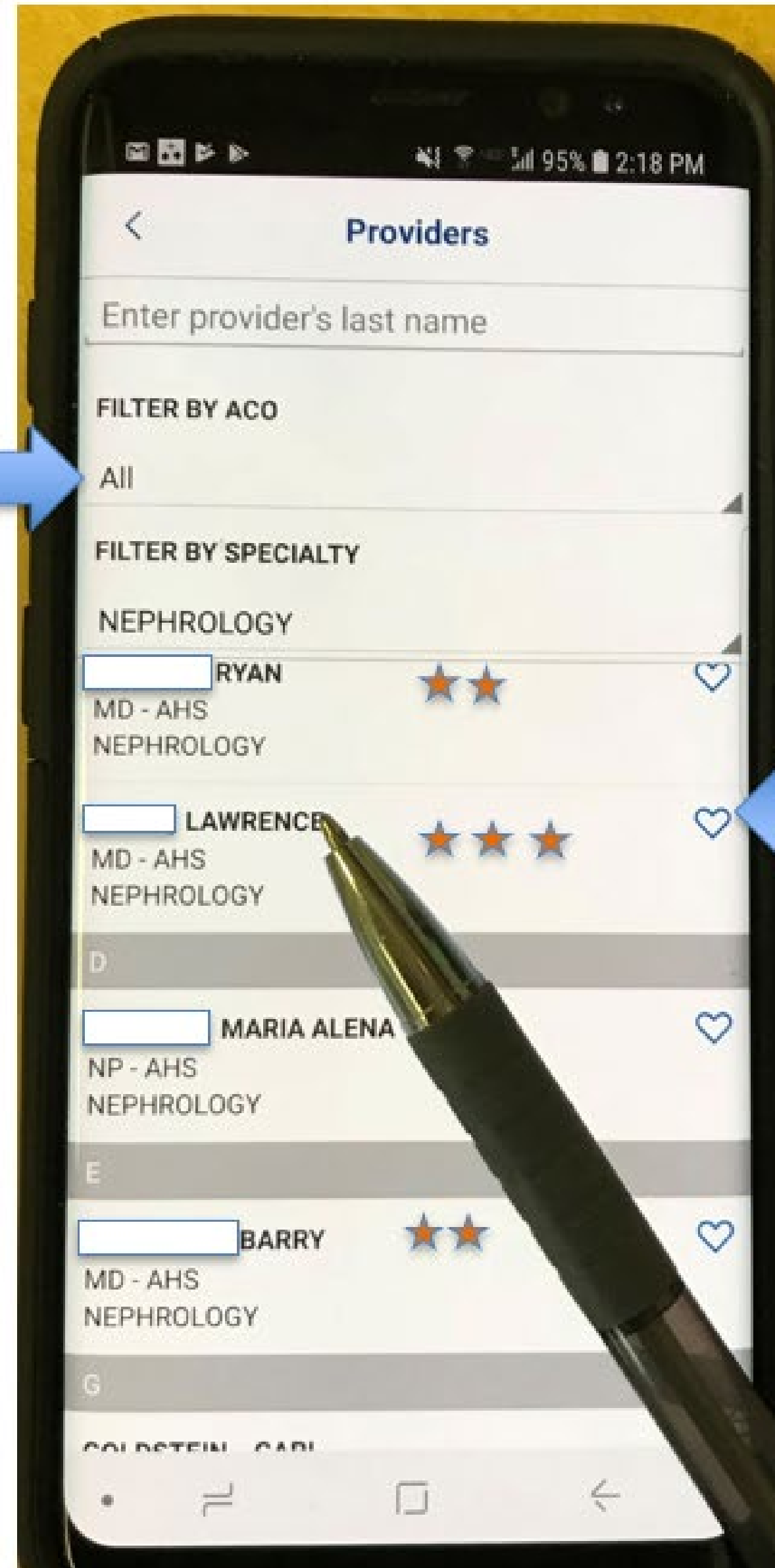
Your selections for your medical neighborhood are listed here



ACO-GO

You can filter by ACO

The Physicians are listed.



Click on the heart, and the physician will be added to your Medical Neighborhood

Specialist Collaboration Survey Questions and Weights -1-

Q5 Please advise which ACO Collaborative Partnership Activities listed below you are currently engaged in? Checkboxes

Insert text from...

Answer Genius ? Select type

Select correct answer below

	Points
<input checked="" type="checkbox"/> Available for on demand phone consults from primary care physicians	- 3 +
<input checked="" type="checkbox"/> Connect to our primary care providers via Secure Chat , direct messaging, or Epic In Basket	- 2 +
<input checked="" type="checkbox"/> Willing to see patient within 24 hours as an emergency room visit follow up.	- 2 +
<input checked="" type="checkbox"/> Offer same day emergency consult appointments	- 3 +
<input checked="" type="checkbox"/> Will call PCP prior to making secondary referrals	- 3 +
<input checked="" type="checkbox"/> Will send consult note to PCP within 48 hours	- 3 +
<input checked="" type="checkbox"/> Will ensure patient follows up with their PCP for regular care	- 3 +
<input checked="" type="checkbox"/> Perform procedural services on our ACO patients within our ACO participant facilities	- 4 +
<input checked="" type="checkbox"/> Allow ACO care coordination team to reach out to mutual patients for transitions of care and high risk care coordination	- 2 +
<input checked="" type="checkbox"/> Maintain a practice specific patient satisfaction survey and share results	- 3 +
<input checked="" type="checkbox"/> Send screening reports i.e. colonoscopy, mammograms, retinal exams to the PCP	- 4 +
<input checked="" type="checkbox"/> Inquire if patient has a PCP, if none refer to ACO PCP in your medical neighborhood	- 2 +

Specialist Collaboration Survey Questions and Weights -2-

<input checked="" type="checkbox"/>	Round more than once a day in the hospital, or discuss case with Hospitalists if patient ready for discharge.	-	2	+
<input checked="" type="checkbox"/>	Will see patients in skilled nursing facilities	-	1	+
<input checked="" type="checkbox"/>	Will see patients in Nursing Homes (long term care)	-	1	+
<input checked="" type="checkbox"/>	Will see patients in assisted living facilities	-	1	+
<input checked="" type="checkbox"/>	Have a "call us first" program in place (describe below)	-	4	+
<input checked="" type="checkbox"/>	Participate in either Bundled Payments or Commercial Episodes of Care Programs	-	1	+
<input checked="" type="checkbox"/>	Participate fully in the MIPS program (not just submitting minimal measures to avoid penalty)	-	3	+
<input checked="" type="checkbox"/>	Do you currently serve on an ACO committee (please advise what committees below)	-	3	+
<input checked="" type="checkbox"/>	Offering appointments after 6PM one day a week	-	1	+
<input checked="" type="checkbox"/>	Offering appointments after 6PM two or more days a week	-	2	+
<input checked="" type="checkbox"/>	Offering Saturday appointments	-	2	+
<input type="checkbox"/>	Offering Sunday appointments	-	0	+
<input checked="" type="checkbox"/>	Completed this survey	-	1	+

REFERRALS: LEAKAGE & KEEPAGE

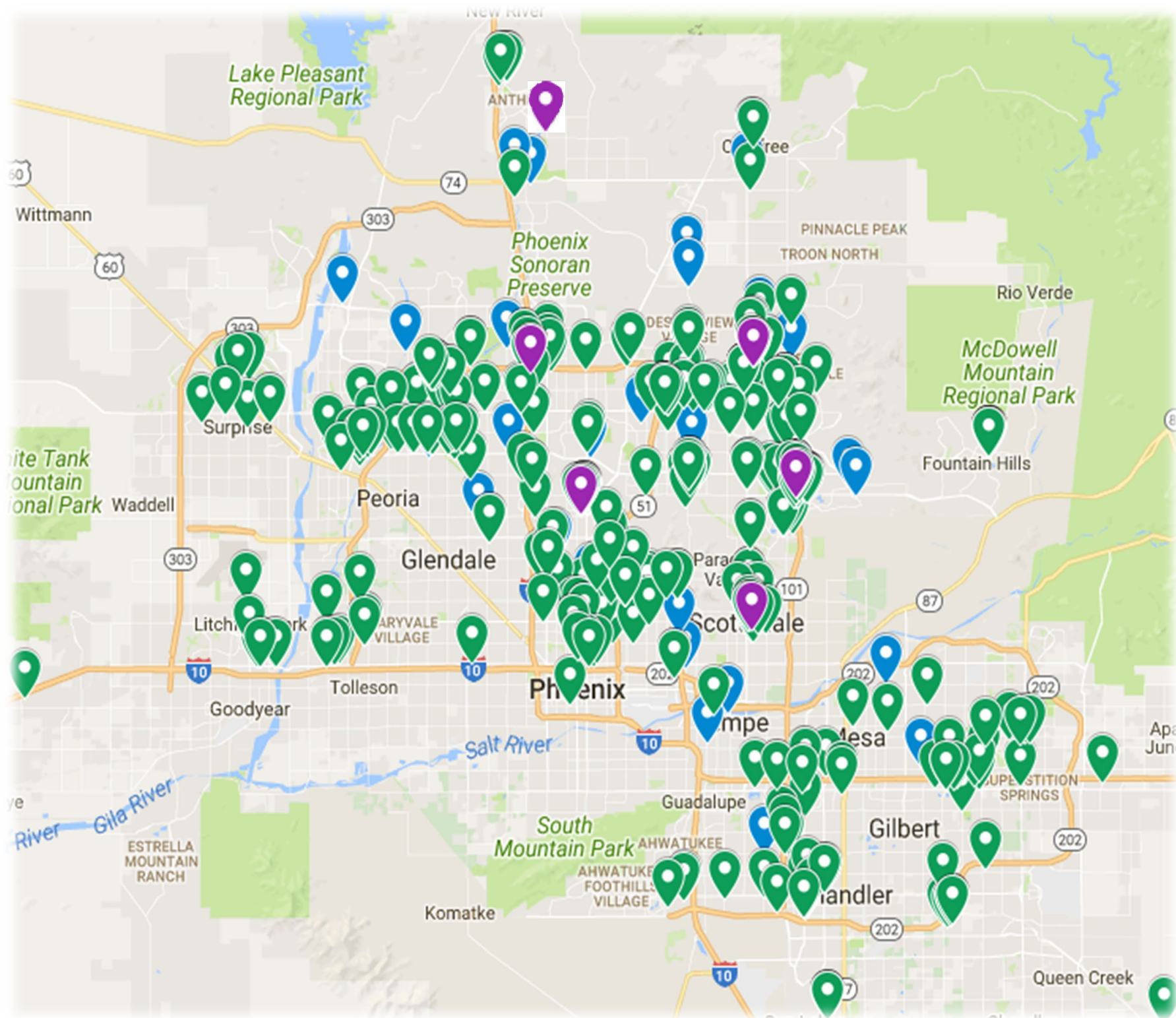
Heather O'Toole, MD, MPH

Chief Medical Officer

Innovation Care Partners

Innovation Care Partners (Scottsdale Health Partners)

Clinical Integration and Accountable Care Organizations



- Specialist Location
- PCP Location
- HonorHealth Hospital

Wholly Owned
HONORHEALTH™

Managed by ICP

Innovation Care Partners
 MSSP
 Commercial
 Medicare Advantage Plans
 Medicaid
 Marketplace
 BPCI-A

- Physician-led ACO formed in 2012
- >2,000 Providers caring for 175,000+ patients
 - ✓ Improved outcomes & evidence-based care
 - ✓ Coordinated care
 - ✓ Reduced healthcare costs
 - ✓ Top quality

Mission – to provide coordinated, high-value, evidence-based care to improve the health and well-being of the patients and families we serve

Why Manage Referrals?



Mechanisms for ACOs to Influence Referrals



Informational

- Distribute referral list
- Relevant criteria
- Electronic referral processes



Nonfinancial

- Feedback reports
- Recognizing PCPs with higher in-network referrals
- Offer positive reinforcement to patients obtaining care within ACO



Financial

- Lowering patient copayments for care obtained within the ACO
- Financial bonuses (shared savings etc.) for referral patterns

*Subject to regulatory permissibility

Referral Management Tool

A web-based referral management platform that **minimizes additional work for clinicians and staff**

Find the right provider for the patient **based on payer, location, and specialty**

Keep referrals **within network to reduce leakage and improve the ability to take on risk with other value-based agreements**

Referral Expectations

ALL ICP Members are **required** to utilize referral platform for referrals in order to *maintain membership* within ICP

Providers have 90 days post ICP start date to begin using the system

PCP

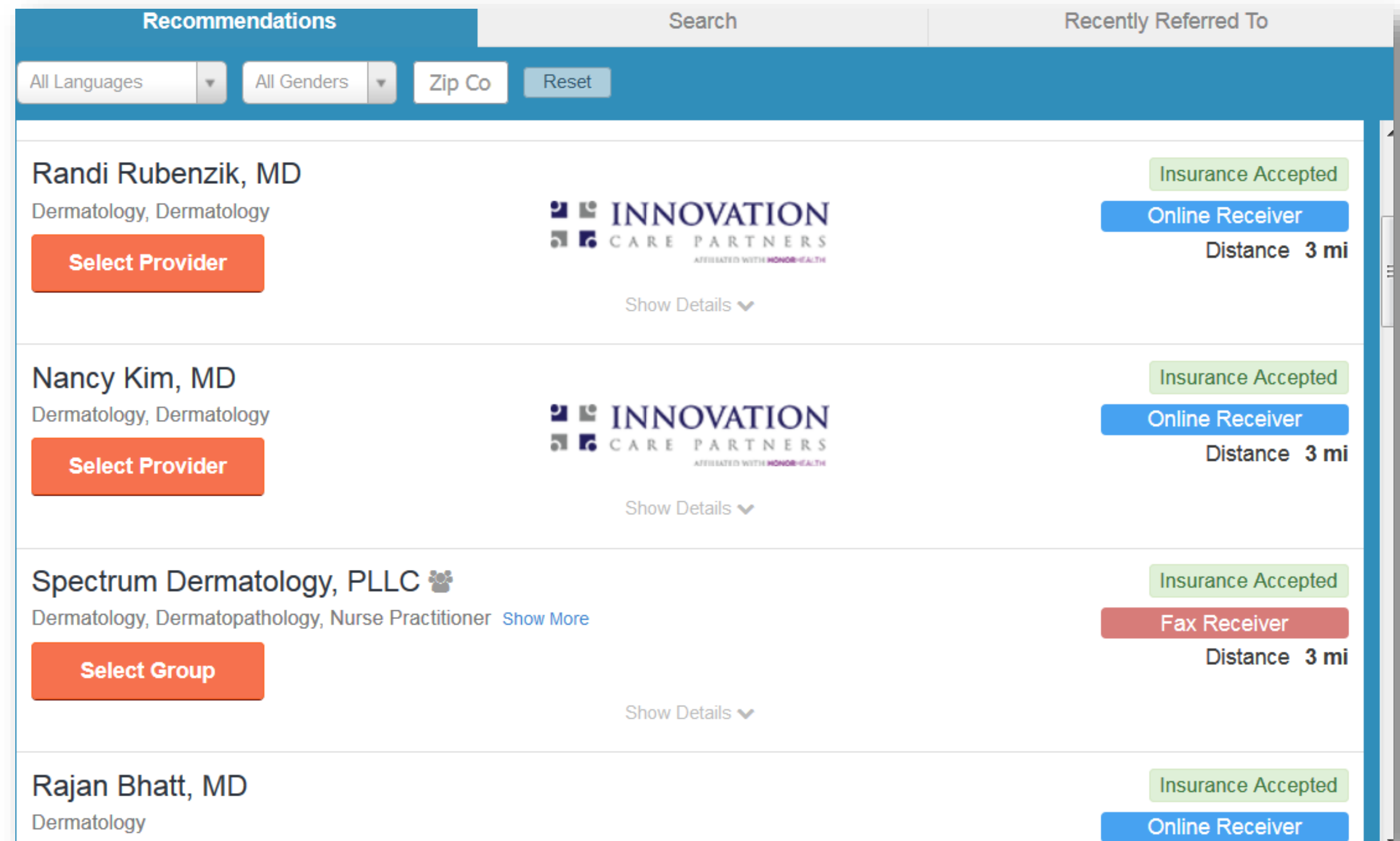
Minimum of 25 referrals per quarter **and** 50% of the previous quarters' volume of referrals, *which ever is greater*, must be SENT online

Specialist

Required to receive referrals online and are required to **manage** referrals in a timely manner

Referral Platform with Ranking

- Referral Metrics
 - Time to First Action
 - Scheduling within Urgency
 - Response Rate
- Specialist closest to your patient, that accept their *insurance* appear first

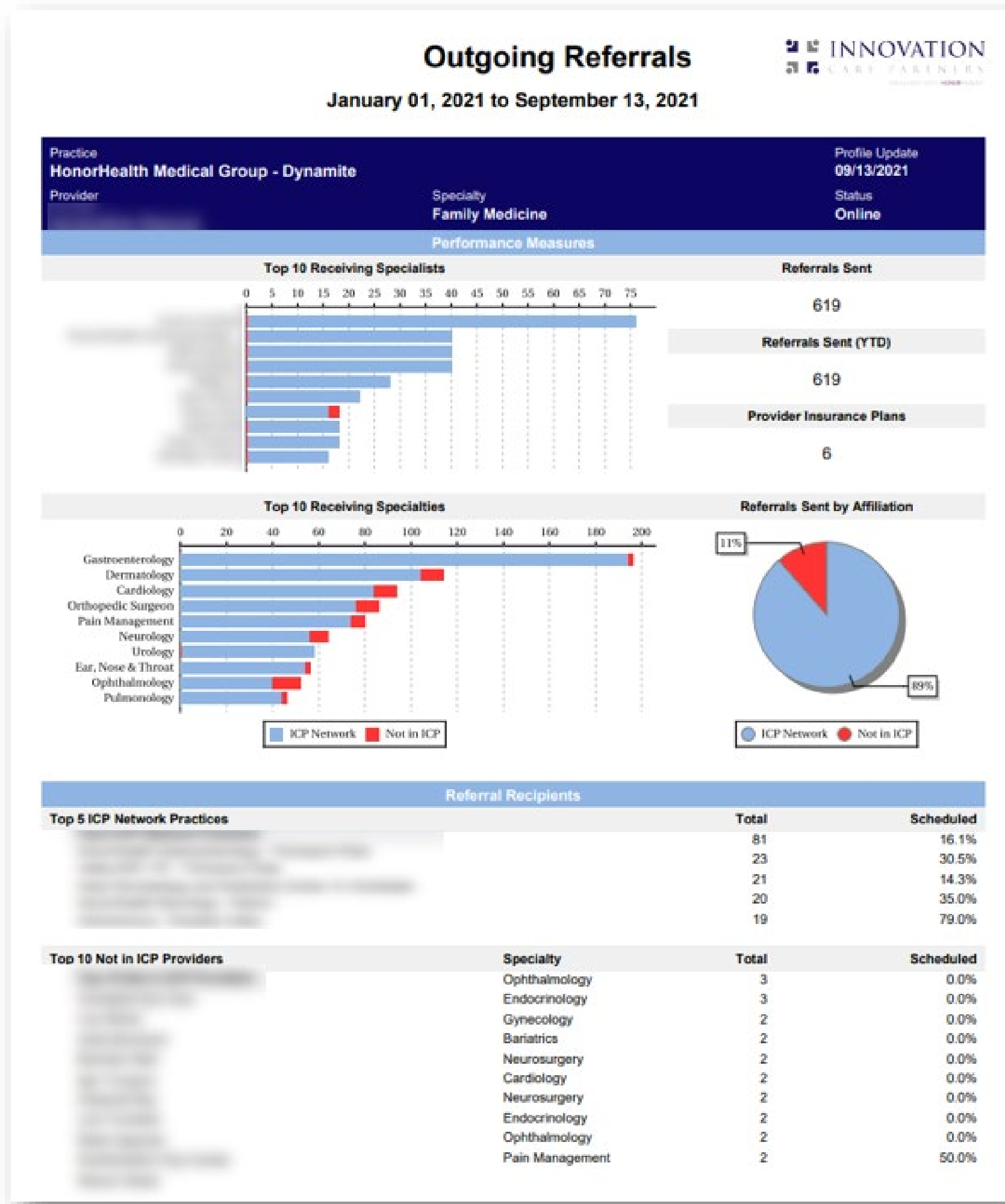


The screenshot displays the 'Recommendations' section of the referral platform. It features a search bar with filters for 'All Languages', 'All Genders', and 'Zip Co', along with a 'Reset' button. The results are listed in a table-like format with the following entries:

Provider/Group	Specialty	Insurance Status	Receiver Type	Distance
Randi Rubenzik, MD	Dermatology, Dermatology	Insurance Accepted	Online Receiver	3 mi
Nancy Kim, MD	Dermatology, Dermatology	Insurance Accepted	Online Receiver	3 mi
Spectrum Dermatology, PLLC	Dermatology, Dermatopathology, Nurse Practitioner	Insurance Accepted	Fax Receiver	3 mi
Rajan Bhatt, MD	Dermatology	Insurance Accepted	Online Receiver	

Each entry includes a 'Select Provider' or 'Select Group' button, a 'Show Details' link, and the Innovation Care Partners logo.

PCP Quarterly Reports



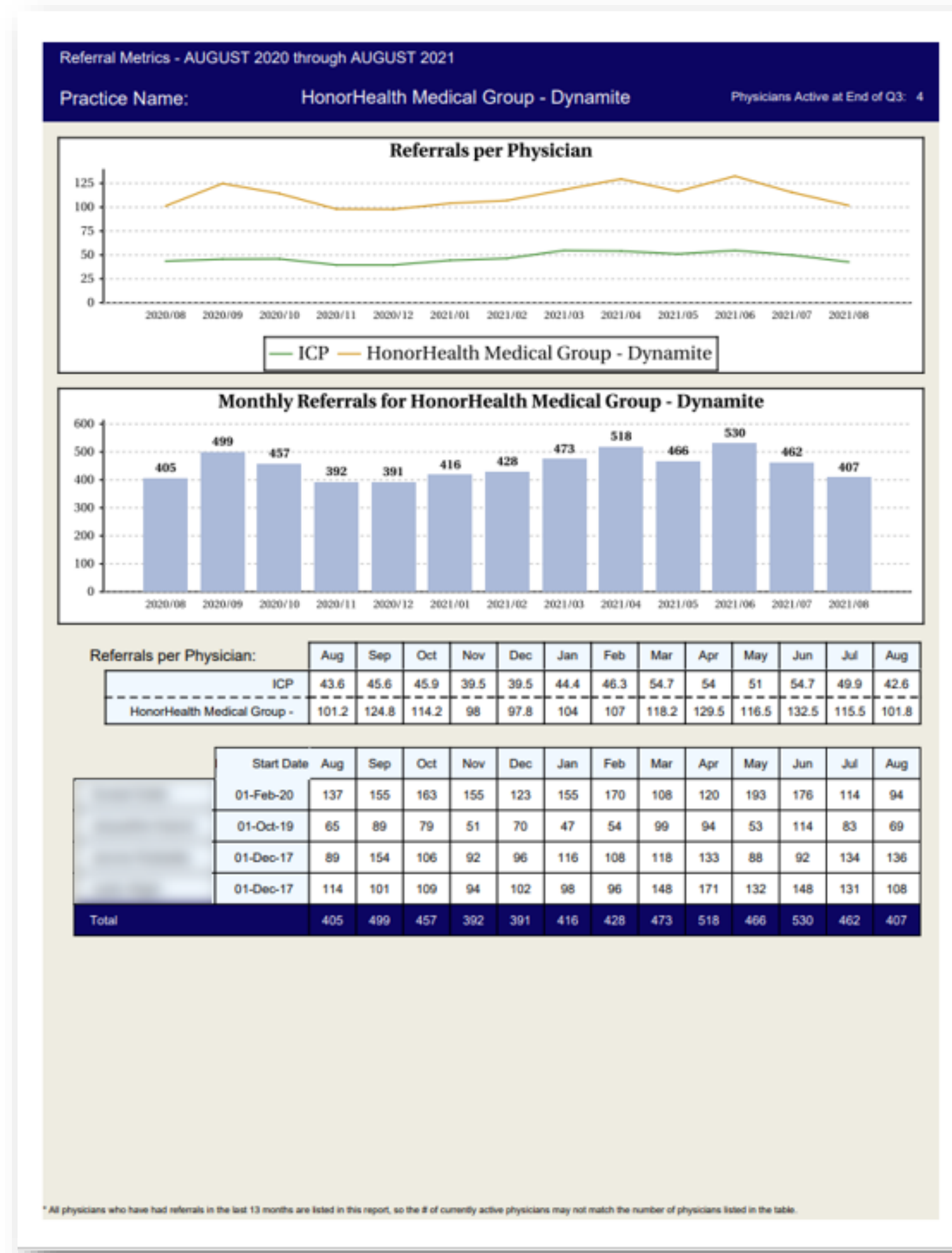
In-network referral rates

Volumes

% Scheduled

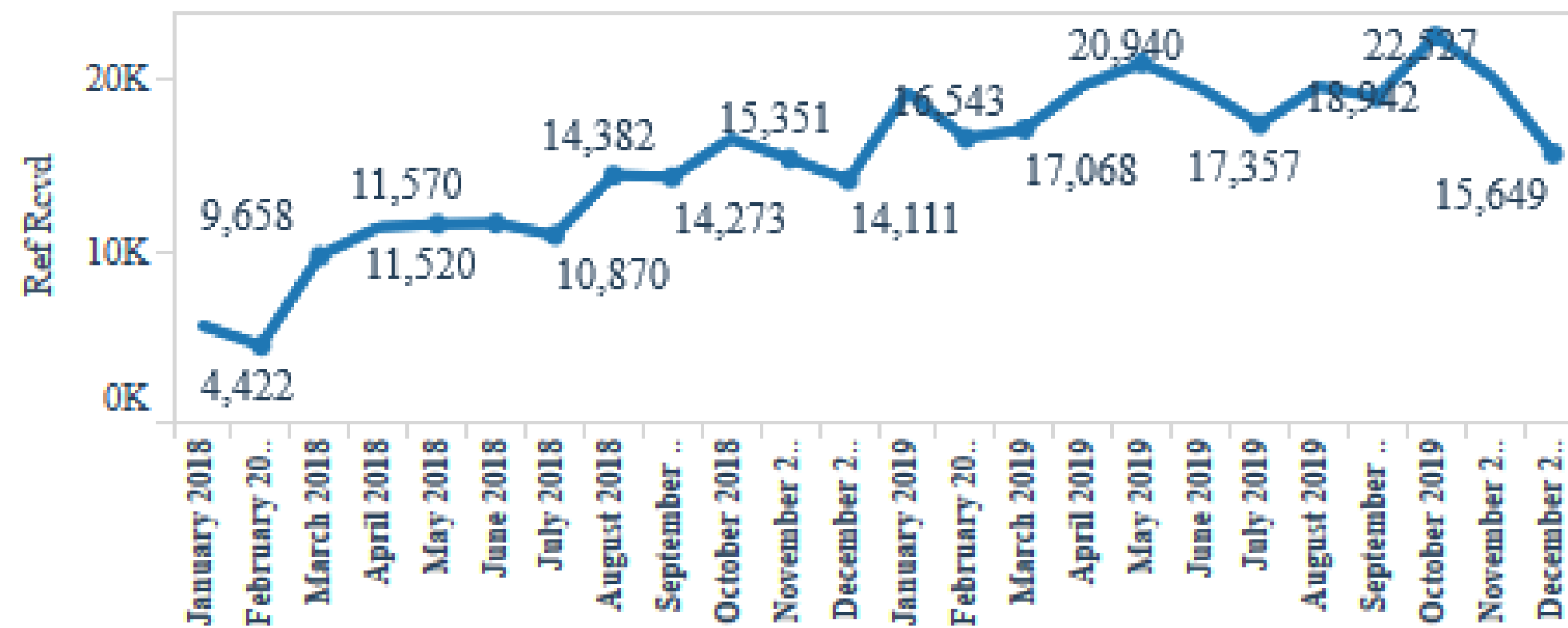
Specialty breakdowns

Face-to-face meetings

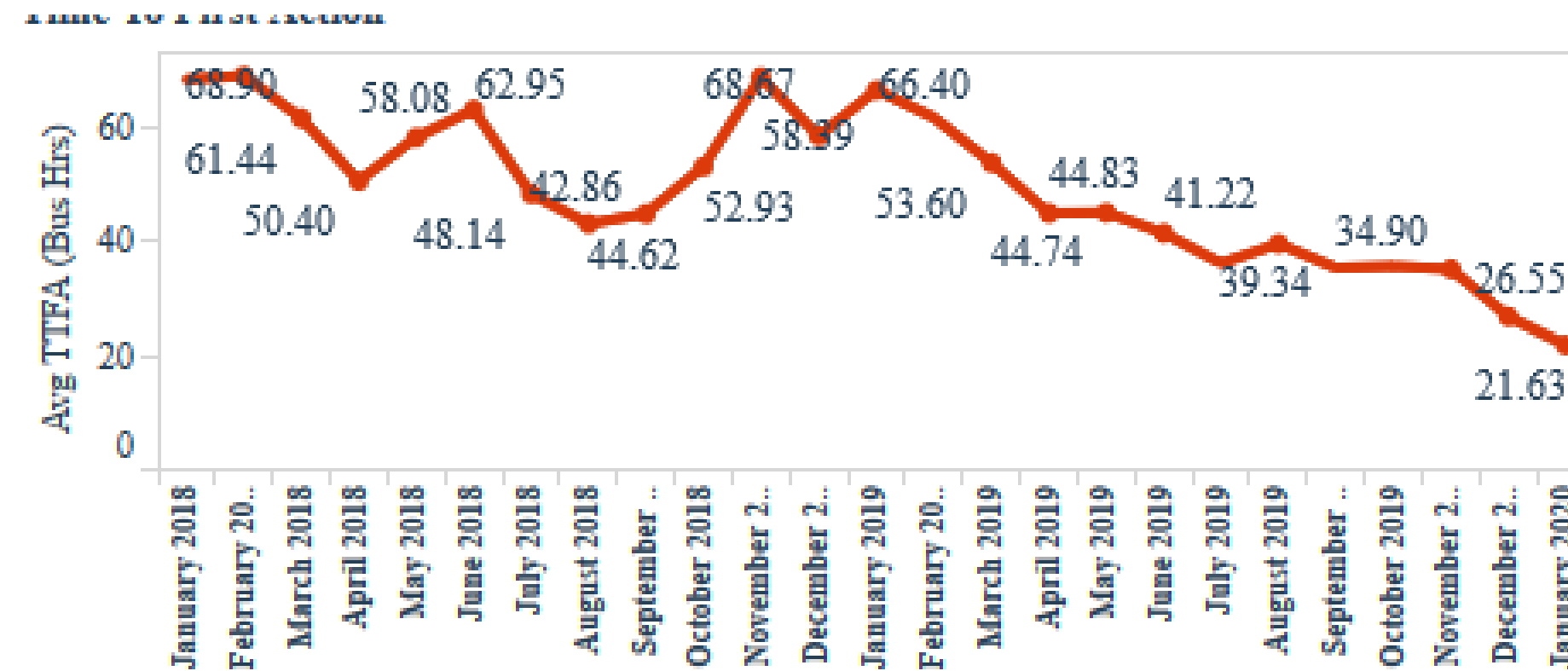


Specialist - Adoption Acceleration

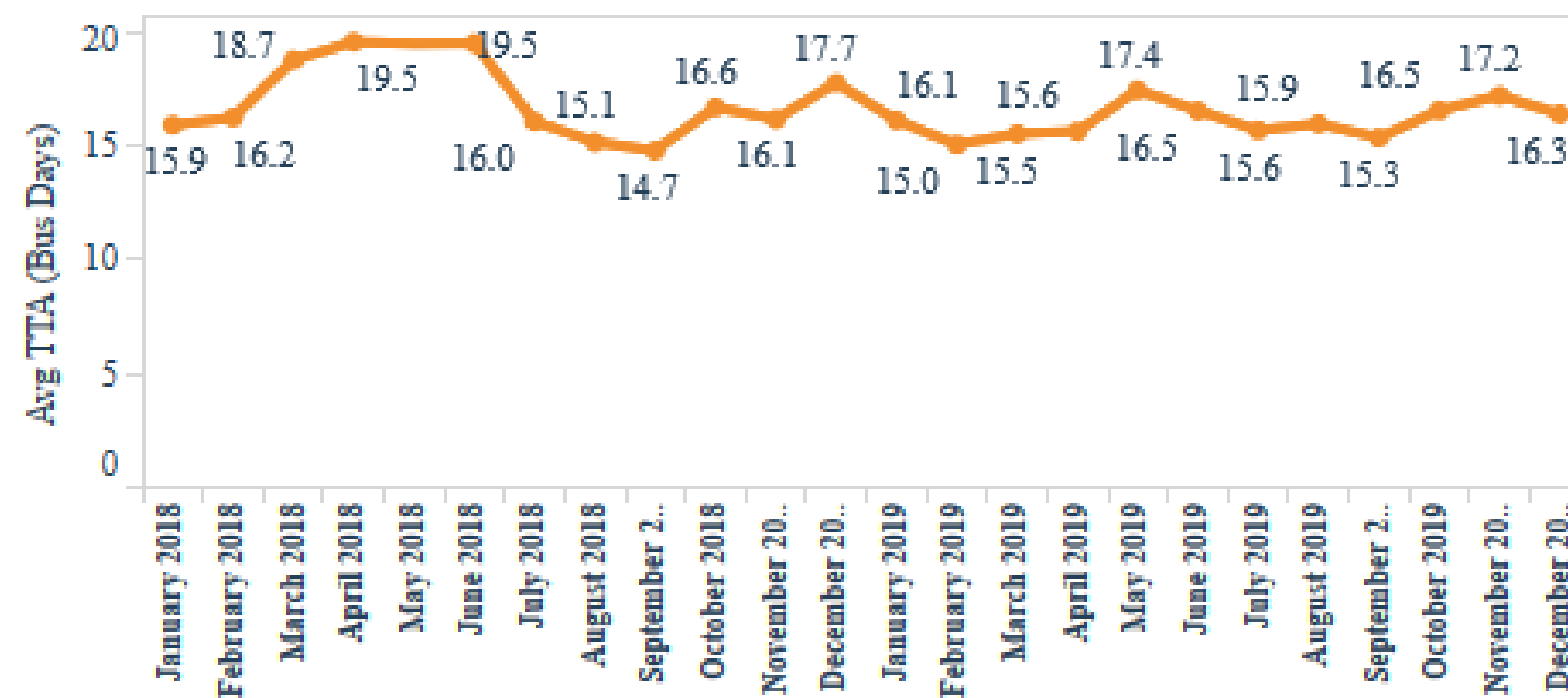
Referrals Received



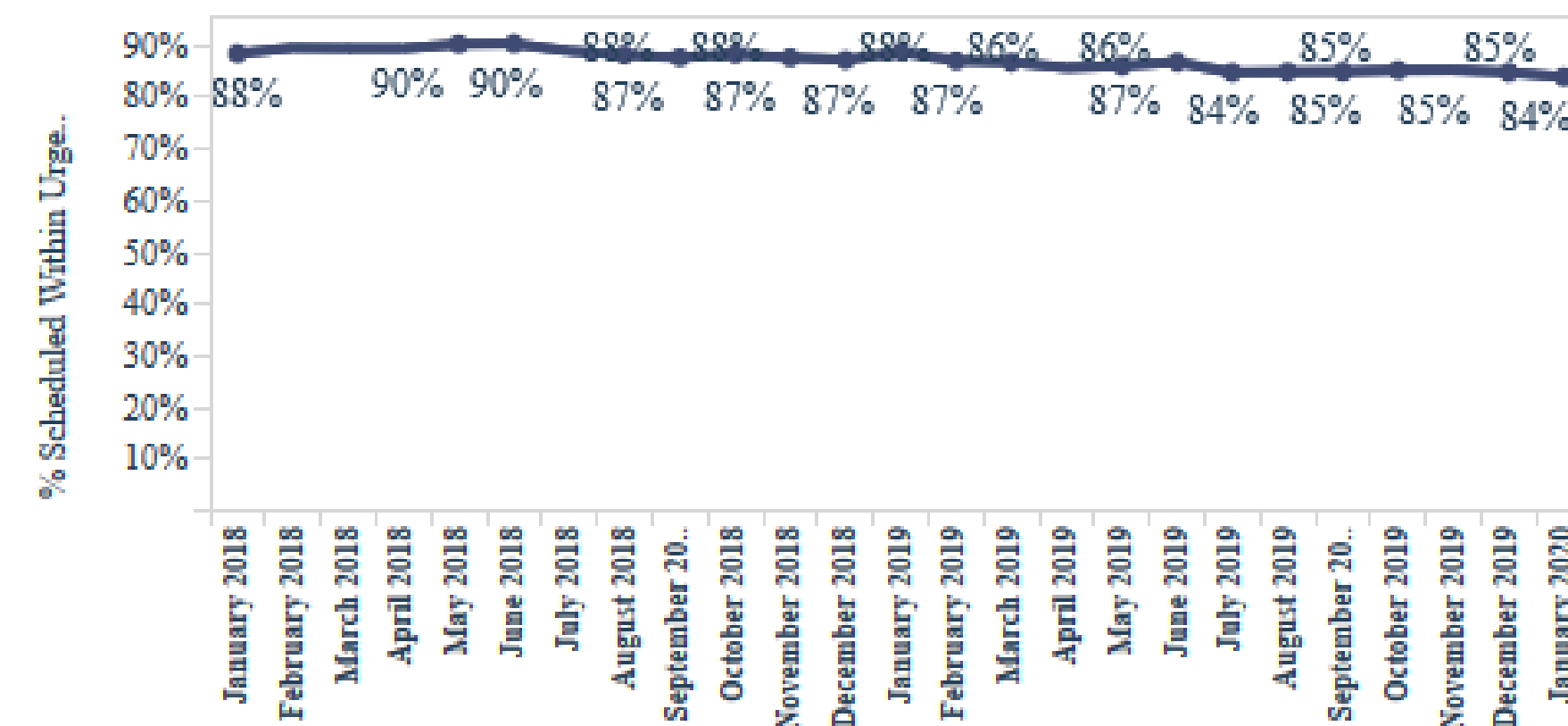
Time To First Action



Time to Appointment



Scheduled within Urgency



Citizenship & Gainshare

Citizenship Category	Patient Care Category	Quality/Performance Category
Opt-In for Communications	HIE Utilization	Quality Initiatives: 4+ Stars rating for MA plan
ICP Meetings participation	Communication Platform Utilization	Advanced Care Planning
Committee participation	Patient Notifications Alerts: Patient Admission/Transfer, Discharge and Admitted to ED	Quality Initiatives: Specialty measures TBD by Work Groups
Work Group participation	Referrals: <ul style="list-style-type: none"> • In-Network Referrals • Specialist Time to First Action • Outgoing Referrals 	Ophthalmology AMD preferred drug for new starts Reading PCP retinal camera reports Gastroenterology Colonoscopies at ASCs Cardiology Quality Scorecard Emergency Physicians Low Risk Chest Pain referrals
Survey participation	Clinical Guideline Development Clinical Guideline quizzes	

✓ **Membership-level Points**

- ✓ **Gainshare Eligible:**
- Higher Points Requirement
 - **Quality Component for Gainshare**
 - *Gainshare, if available, will be distributed on an annual basis and ICP activities in the previous 12 months will be used to track these points*

Challenges

Referral Platform

- User Access
- EHR Integration

Driving Referrals

- Patient Request & Continuity of Care
- Provider Patterns
- Network Gaps
- Selective Use – Minimums only, PPO vs HMO

2ndary Referrals

- Specialist to Specialist
- PCP changes

QUESTIONS?

Thank you!

Heather O'Toole, MD, MPH
hotoole@icphealth.com



Clinical Integration & Referral Management at Summit Health

NAACOS Panel 2021

Presented by: Dr. Jack Cappitelli, M.D.
Chief Medical Officer – New Jersey Region



AGENDA

- Summit Health Overview
- Our Clinical Model
- Provider Referral Expectations
- Referral Management Platform
- Reporting and Provider Performance Management



Summit Health

Overview

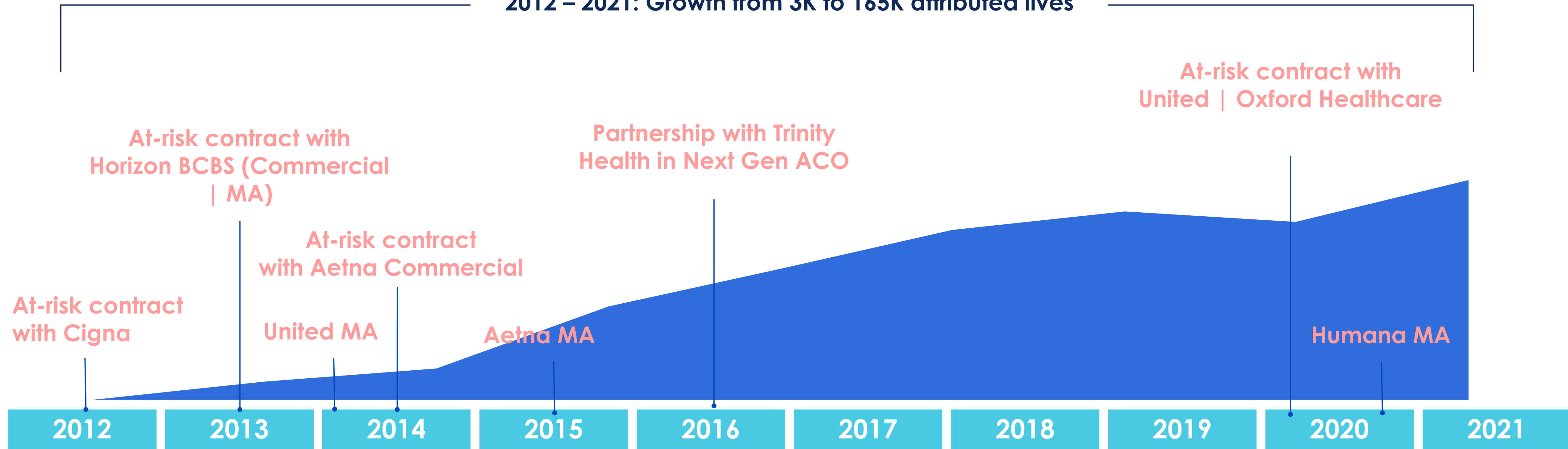
Summit Health: Care at every connection



“At Summit Health we provide urgent to specialty care – with coordination, convenience, and kindness.”

Our strategy: progressive growth and increases in risk

2012 – 2021: Growth from 3K to 165K attributed lives



Increasing our provider count and VBC risk progressively was key to our success

Effectively linking primary care growth and transformation with VBC contract terms allowed us to develop win-win arrangements over time

Progressive VBC success enabled further investment in value-based care capabilities

Revenue = FFS



Revenue = FFS + V_(Value)



Clinical Model

Connected, collaborative and personalized care

Clinical Call to Action

- **Prove great care:** satisfy quality measures
- See something, say something
- Ensure every encounter is a positive experience

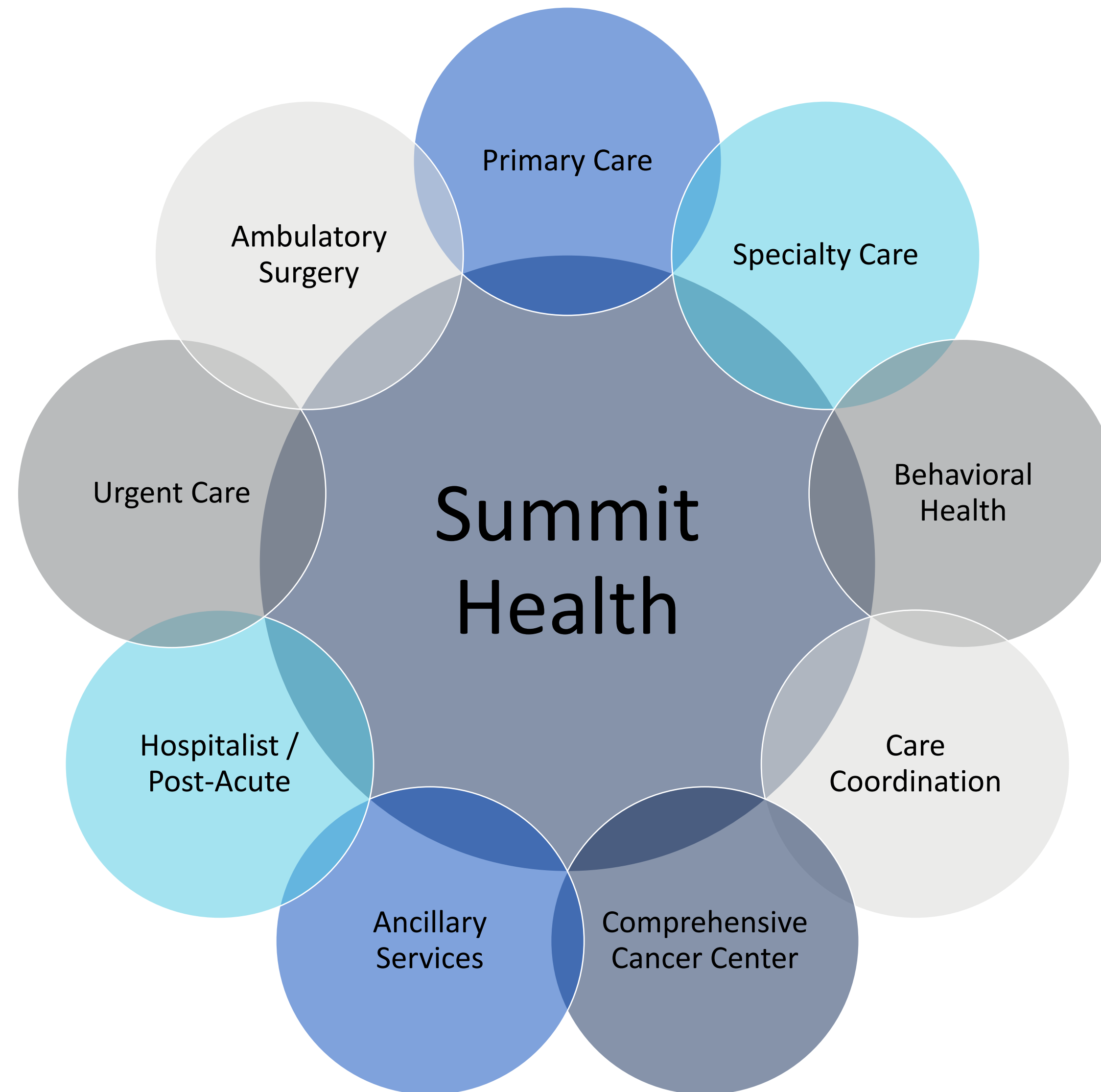
- **Get credit for great care:** capture disease burden by addressing and accurately coding patients' conditions

$$\begin{array}{c} \mathbf{V} \\ \text{(Value)} \end{array} = \frac{\mathbf{Q} + \mathbf{D}}{\mathbf{\$} \text{ (Cost)}}$$

The diagram illustrates the equation for Value. On the left is a large red 'V' with '(Value)' below it. To its right is an equals sign. Further right is a large blue 'Q' with '(Quality + Pt. Exp)' below it. To the right of 'Q' is a plus sign '+'. To the right of the plus sign is a large grey 'D' with '(Disease Burden Capture)' below it. A horizontal line is drawn under the 'Q + D' part of the equation. Below this line is a large green '\$' with '(Cost)' to its right. A light blue arrow points from the top-left box to the 'Q'. A light grey arrow points from the top-right box to the 'D'. A light green arrow points from the bottom box to the '\$'.

- **See benefits of great care: better** outcomes at a lower cost
- Keep it in the family
- Choose wisely: avoid low-value and unnecessary services
- Keep patients out of expensive settings (hospitals, SNFs)

Keeping Care In the Family



When Patients Leave Home...



Hospitalist / Post-Acute Care Model

- (1) Admit and manage Summit patients at highest volume hospitals and skilled nursing facilities
- (2) Refer to Summit specialists as needed and support our specialists practicing in the inpatient setting
- (3) Identify and care for patients who may otherwise be referred outside Summit
- (4) Ensure coordination of care and referrals back to primary and specialty care for follow up
- (5) Nurse Care Managers identify and manage patients in facilities where Summit Hospitalists do not provide care
- (6) Identify patients in the ER who can be diverted back to primary or urgent care at Summit to avoid admission

Educating patients about the value of connected care...

Communications campaign promotes the experience of connected, collaborative and personalized care

The screenshot shows a website page with a dark header image of a doctor and a patient. The main content area is white and features a navigation breadcrumb, a main heading, a sub-heading, a paragraph of text, a link, and three feature cards. The feature cards are dark blue with red circular icons and white text.

summithealth.com/connectedcare

Welcome to Connected Care

🏠 - Welcome to Connected Care

Care at every connection.

At Summit Health we provide urgent to specialty care—with coordination, convenience, and kindness.

[FIND A DOCTOR](#)

- Connected Experience**
200+ Locations
- Collaborative Team**
80+ Specialties
- Personalized Care**
2000+ Providers

EHR Referral Tracking Enhancements

Smith
F 06-26-1963 #1234

orthopedic referral in SUBMITTED to [redacted] (created 11-12-2020 02:07 PM by ATHENA) #111111

Referral status
Order submitted

Order — 2 — Consult Visit — 3 — Consult Note

Scheduling
STAT - Schedule now

Documents (8)
6 lab results,
1 encounter note,
1 imaging result

Insurance
Auth approved
(#9876543210)
Aetna PPO
HealthManager
Network

Print barcode labels for order results PRINT

Department	MAIN OFFICE
Description	ORTHOPEDIC REFERRAL
Diagnosis	Pain in left knee
ICD-10	M25.562 Pain in left knee
Decline	<input type="checkbox"/>
Clinical Provider	[redacted] Grey MD: 1234 Central St Ste A Anytown, CA 99999, Ph (123)456-7890, Fax (123)456-7890

- Automatically links referral order to appointment
- Schedule directly from a referral order
- Increases visibility of referral status
- Improves workflow for clinical staff
- Improves identification of patients needing follow up
- Will feed our referral management platform



Referral Management

Expectations for Providers



Directed Referral Policy

Goal: Ensures our patients receive high quality, cost-effective coordinated care by reducing duplicative tests, divergent medical records and inappropriate care variations.

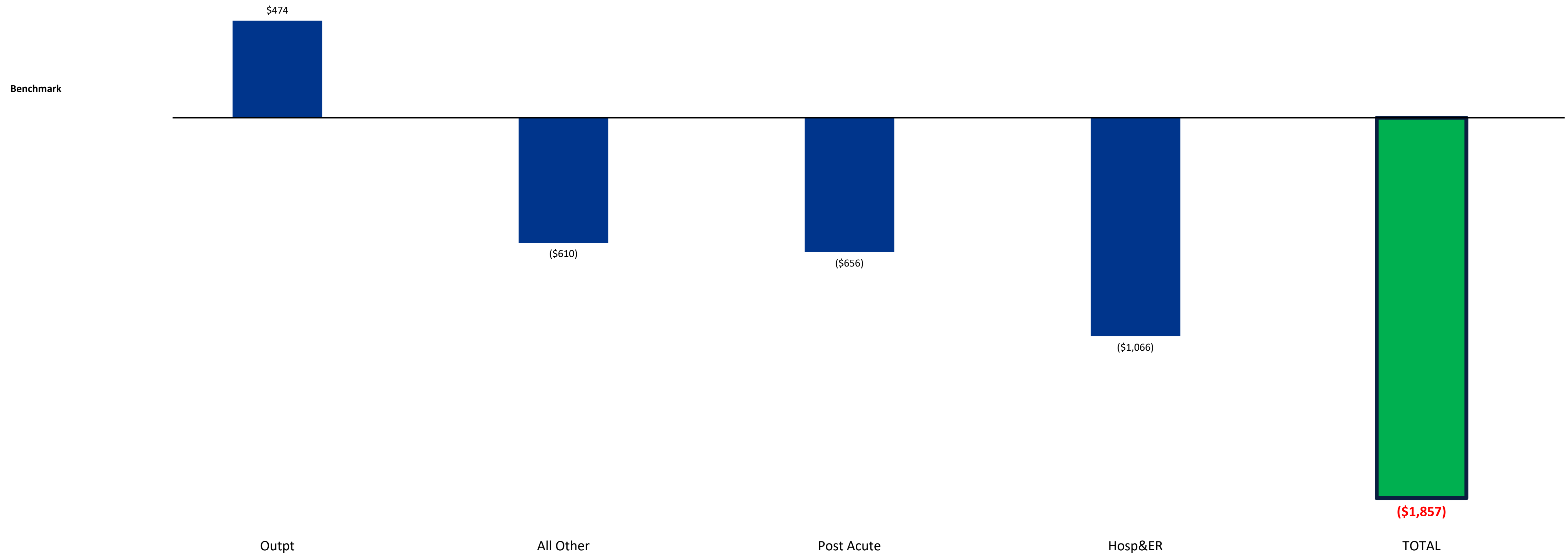
All Summit physicians and providers are educated and encouraged to "keep care in the family" at Summit Health.

Exceptions:

- Medical Judgment
- Patient's Right to Choose
- Insurance Requirements

Lower Cost of Care Despite Increased Ambulatory Care

Our greater ambulatory spend results in greater inpatient savings and lower total cost-of-care Per Member Per Year (PMPY)



Regional Networking



SMG Band



Imagine



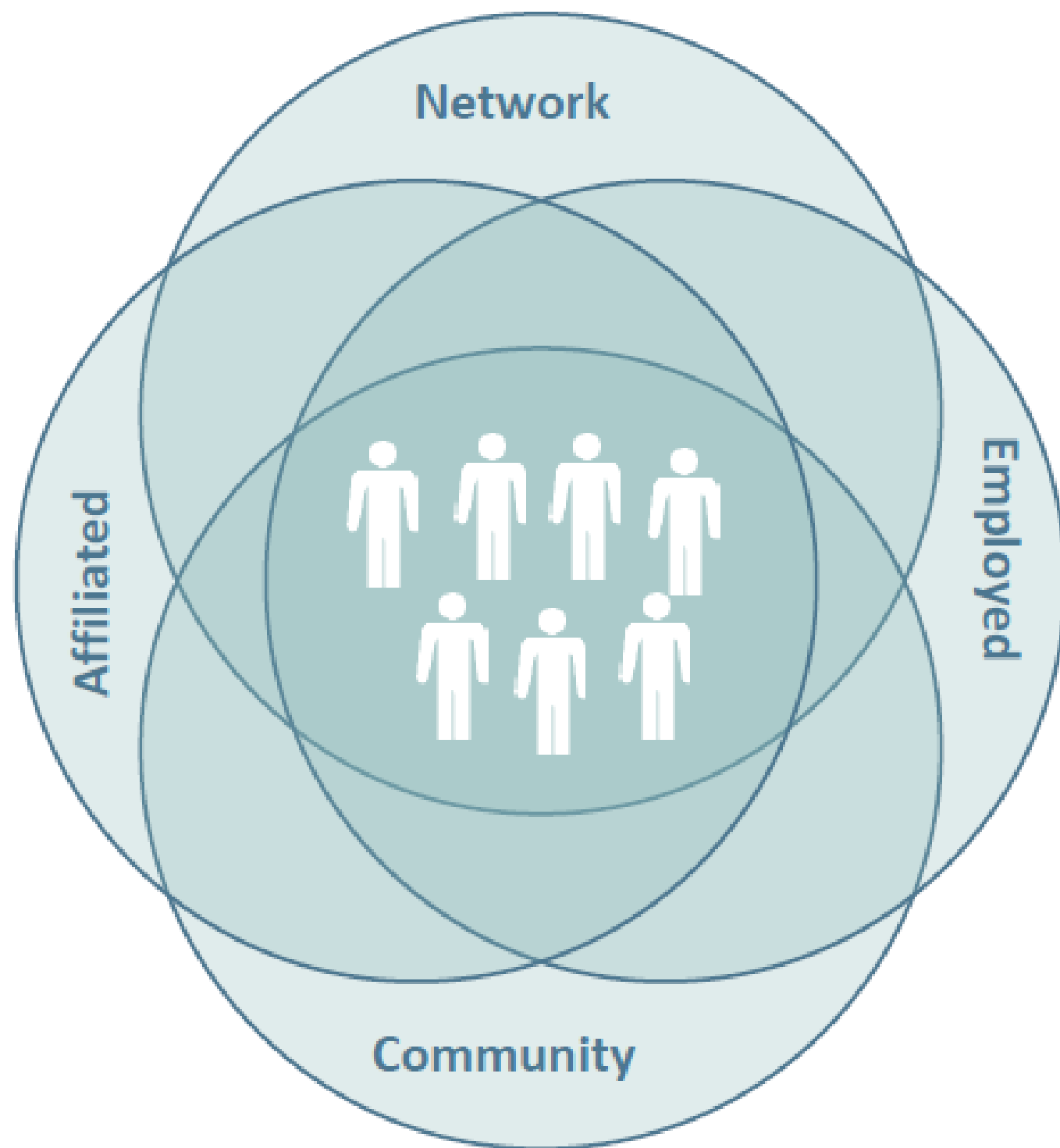
Referral Management

Platform



Referral Management Platform

Source of truth for provider data across all plans with ability to attribute patients

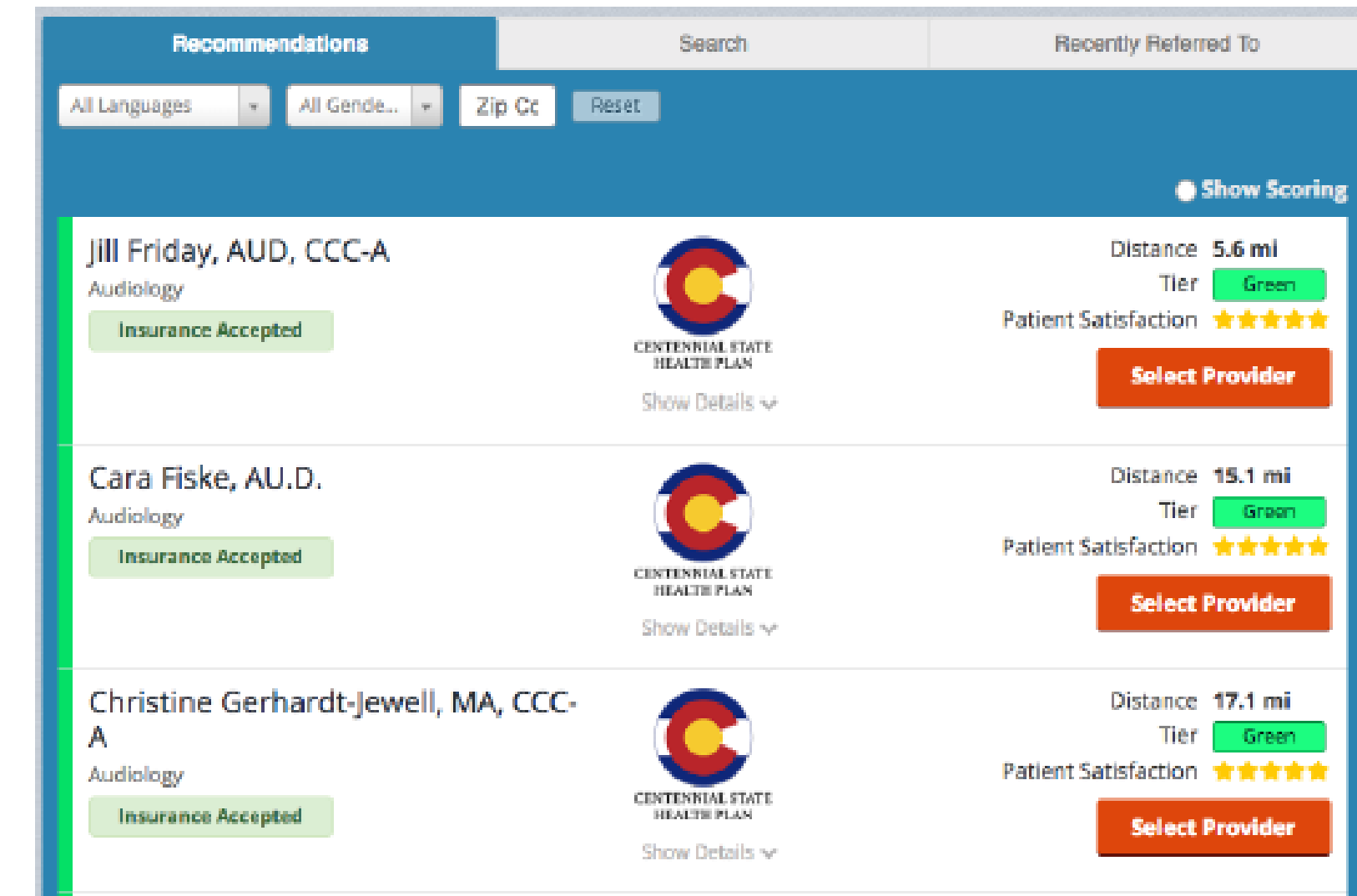


Networks are defined by provider, location(s), plan participation

Each plan's rules are built into the vendor's care compass

- ✓ ACO
- ✓ Employer Contract
- ✓ FFS
- ✓ MSSP
- ✓ Tiered Plans

At the moment of referral, the vendor shares a "care compass" with the provider/staff to recommend the best resource for that patient



Referral Management Workflow



Provider initiates referral

guides Provider Selection

Sending staff sends referral (central or decentralized)

Referral received (centralized or decentralized)

Receiving staff close the loop

EMR referral order pre-populates vendor's referral form with patient demographics and clinical information

Staff finalizes referral and selects receiving provider or group in care compass, then sends referral

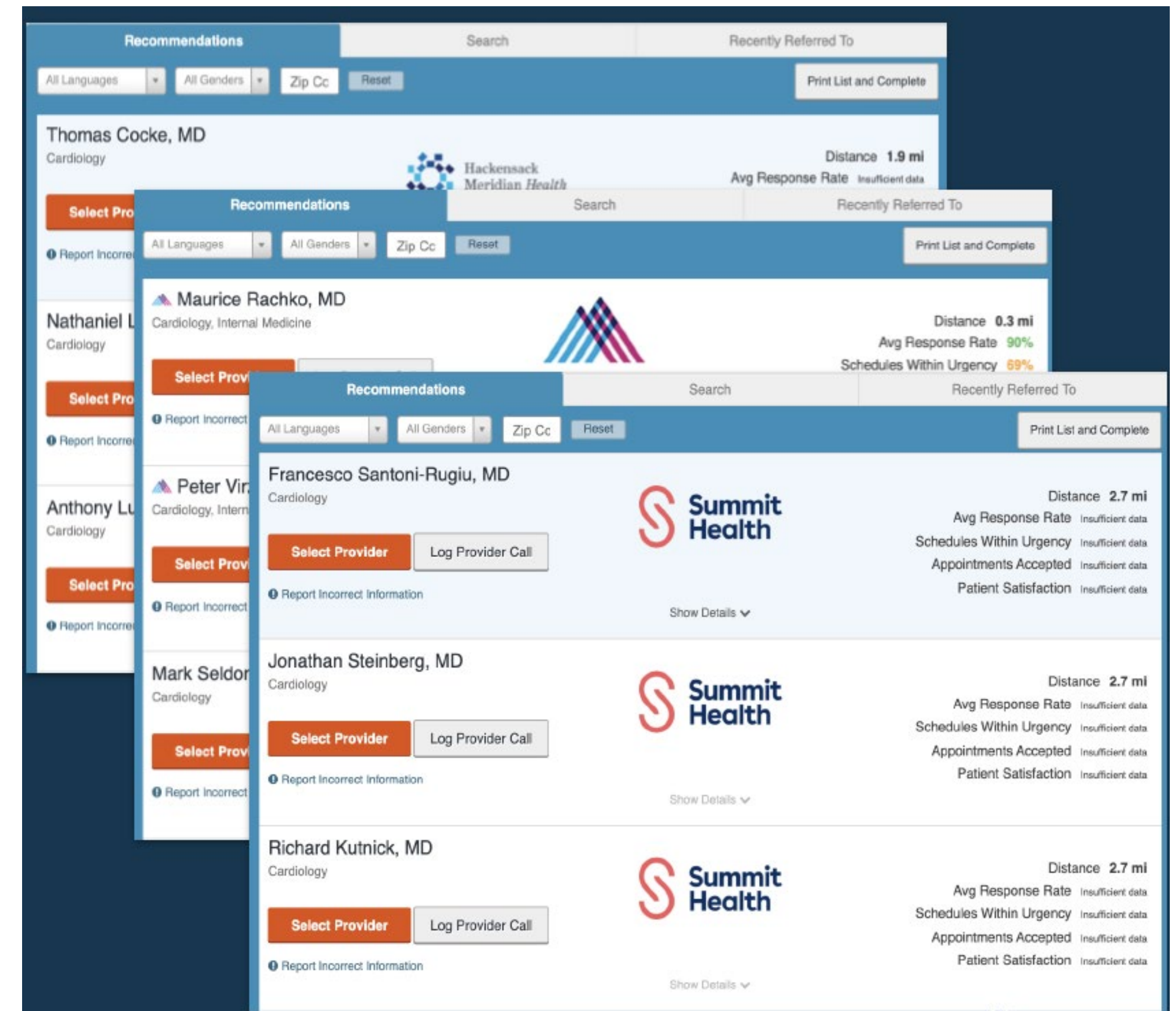
Staff confirms information and securely sends referral

Receiving office or group receives referral email notification and documents patient contact and/or scheduled date/time

Receiving staff returns consult notes via vendor once scheduled date/time passes

Elements Used to “Rank” Provider Options

1. Summit Health Preferred Provider
2. Accepts Patient’s Insurance
3. In Geographic Region
4. Provider Access (available appointments when needed)
5. Provider Historic Responsiveness to Referrals
6. Patient Satisfaction (NPS Score)
7. Provider/Group’s alignment with VBC initiative (i.e., collaborative partnerships with specific programs)





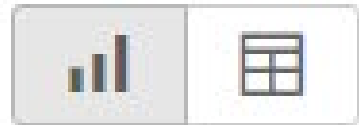
Referral Management

Reporting and Provider Performance Management



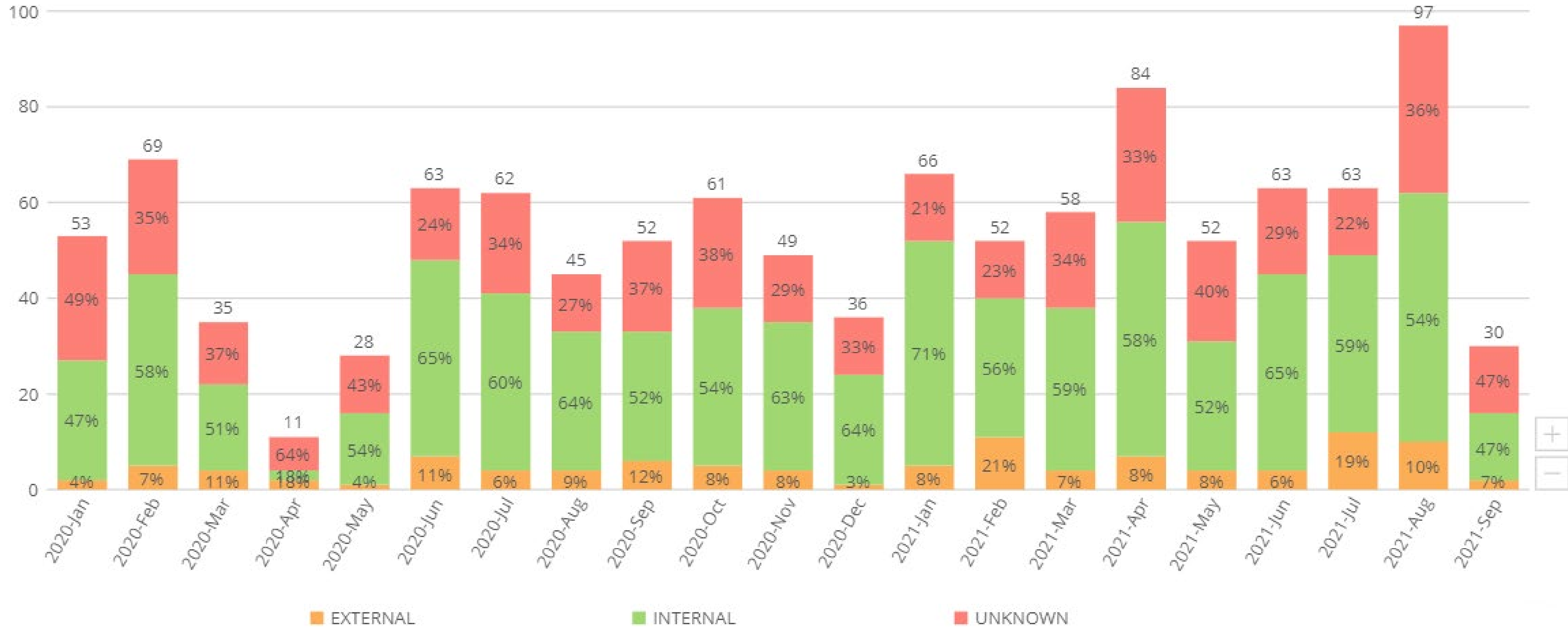
Primary Care Department: Referral Orders

214,575 Count of Orders



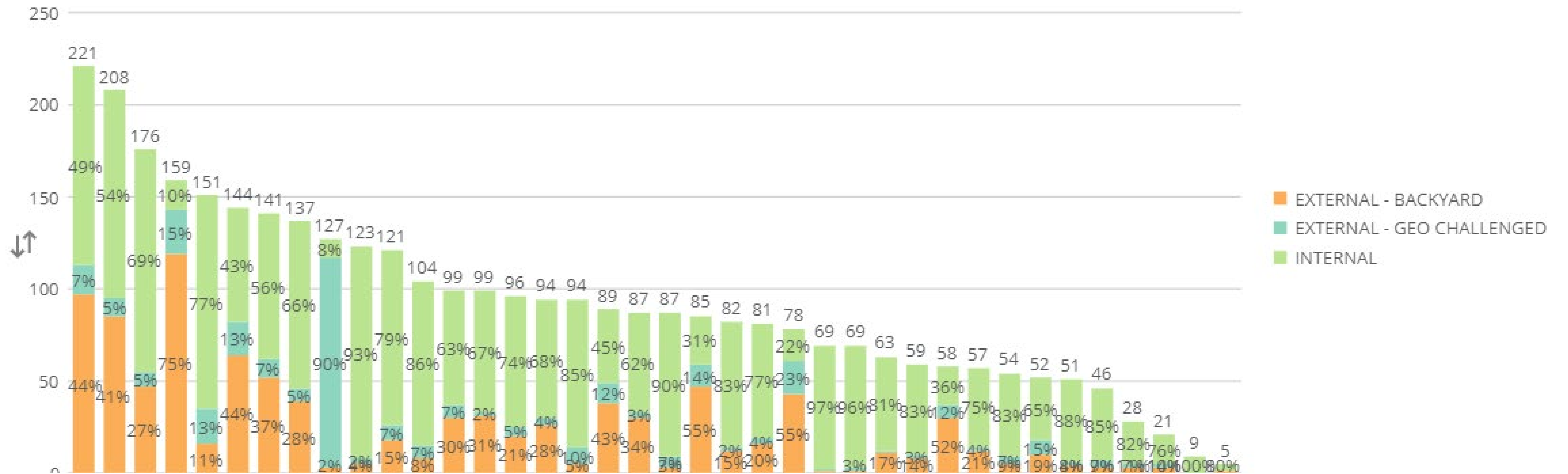
PCP Specific: Referral Orders

1,129 Count of Orders



OB/GYN Mammogram Orders

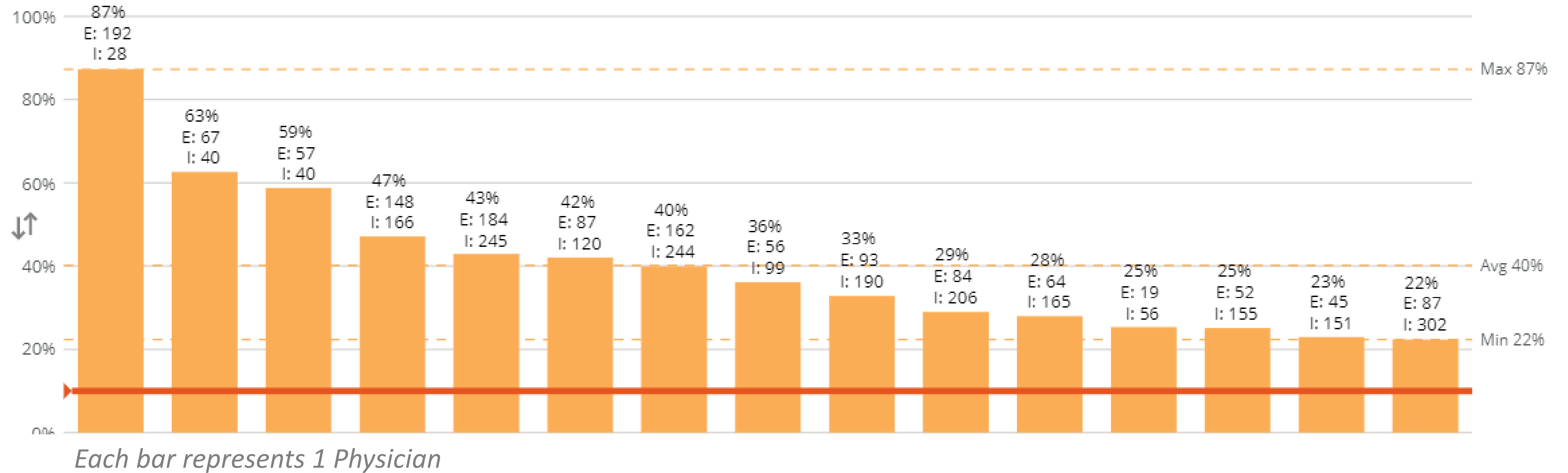
(Internal vs. External)



Each bar represents 1 Physician

OB/GYN Imaging Orders Sent Outside of Summit

Target line to be under: **10%**



Limitations of Managing Leakage and Clinical Integration

- Scaling and investment are critical in several key areas:
 - Real estate development
 - Physical space adequate for clinical programming
 - Provider recruitment and retention
 - Provider onboarding and training
 - Staff recruitment and retention
 - Patient education and engagement related to value of integrated care
- Working with insurers to influence benefit design to align with goals of coordinated care
- Identifying and managing partners in the community, e.g. hospital and SNF partners

Clinical Integration within your ACO/CIN:
Managing the Challenges of Keepage and Leakage
Data, Analytics & Reporting

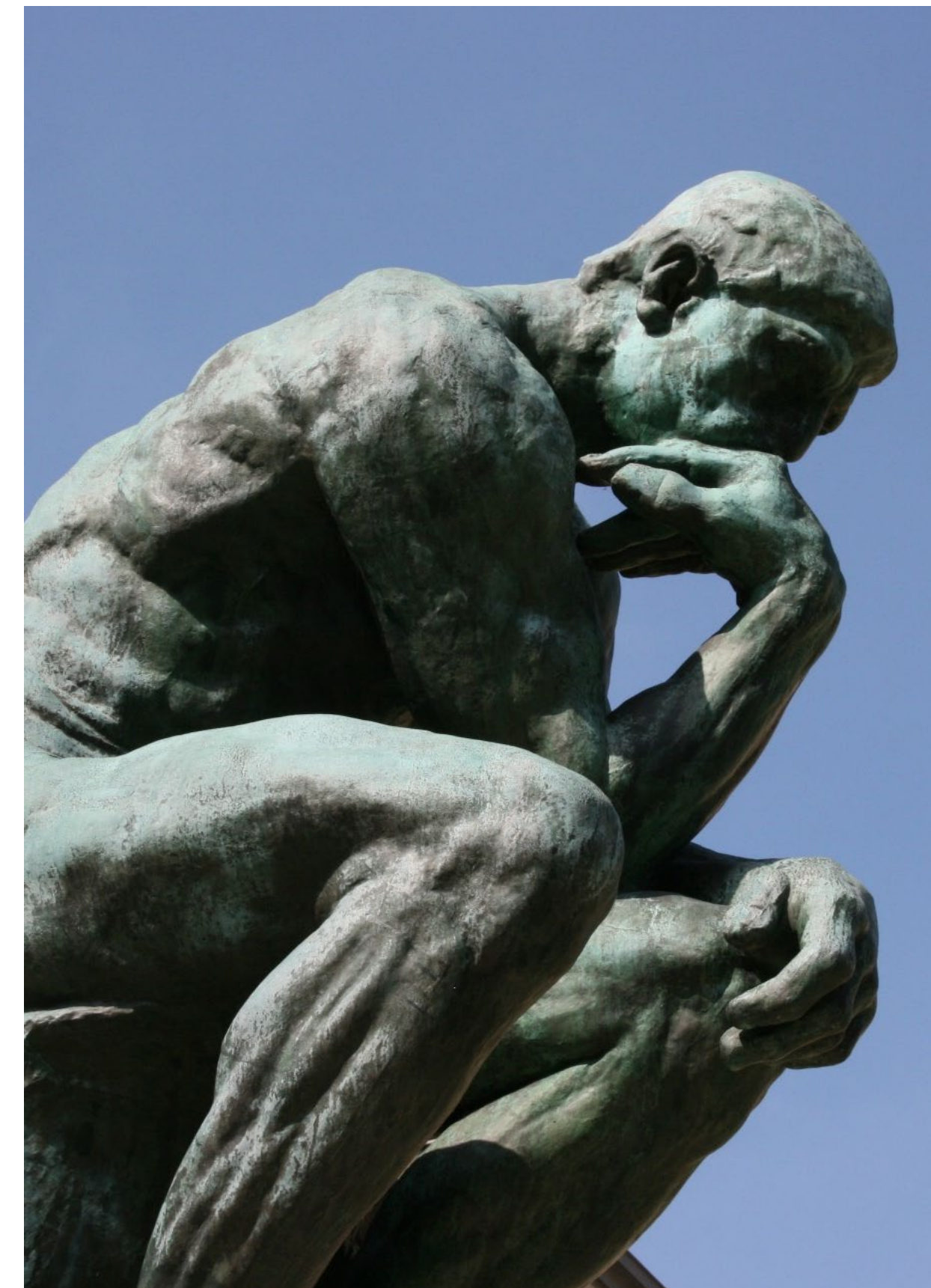
Jim Barr, MD
(james.barr@atlantichalth.org)

VP Physician Value-Based Programs, CMO
Accountable Care

 [Atlantic Health System](http://atlantichalth.org)

Decisions:

- **Claims vs EMR/Practice Management Data**
 - Total, inpatient, outpatient, professional services
 - Elective inpatient, no transplants
- **Definition of “In-Network”** – ACO, system, payer, TIN, Group, practice, provider, rendering/billing/admitting
- **Clinical Taxonomies** – specialty vs DRG or CCSR
- **Reporting Issues:**
 - Costs vs # claims vs # unique patients – outliers
 - Accuracy of reporting – pharmacy, infusions, cardiology readings, rehab inpt, SNF...
 - Regional scoring and comparisons
 - Trend periods
 - “New” referrals



The Most Important Decision - WHY?

- Patient Outcomes
- Performance
- Risk-Taking



AHS Integration Summary - Reporting Levels



Atlantic Health System: Department of Clinical and Business Intelligence

V. Overall MSSP Practice Integration 20200401-20210331

13 Specialties, Elective Procedures, No Transplant Procedures

Timeframe: 20200401-20210331

Using DRG to Specialty Mapping for Inpatient Services and New Referrals Methodology

Region	Group	Practice	Grand Total Payment	Total % In-Network	Inpatient Out-of-Network	Inpatient In-Network	Inpatient % In-Network	Outpatient Out-of-Network	Outpatient In-Network	Outpatient % In-Network	Specialist Out-of-Network	Specialist In-Network	Specialist % In-Network
CENTRAL	AMG												
NORTHERN	AMG												
EASTERN	AMG												
WESTERN	Independent												
CENTRAL	Independent												
NORTHERN	AMG												
CENTRAL	AMG												
CENTRAL	AMG												
NORTHERN	Independent												
CENTRAL	AMG												
EASTERN	AMG												
CENTRAL	AMG												
WESTERN	Independent												
SOUTHERN	AMG												
OTHER	Independent												
CENTRAL	PCP												
CENTRAL	AMG												
WESTERN	Independent												
EASTERN	Independent												
SOUTHERN	AMG												
EASTERN	AMG												
NORTHERN	Independent												
CENTRAL	Independent												
CENTRAL	AMG												
CENTRAL	Independent												
NORTHERN	Independent												
CENTRAL	PCP												

Integration by Specialty and by Region



Atlantic Health System: Department of Clinical and Business Intelligence

IV. 12 Months ACO MSSP: Drilldowns for Regions and Specialties

13 Specialties, Elective Procedures, No Transplant Procedures

Timeframe: 20200401-20210331

Using DRG to Specialty Mapping for Inpatient Services and New Referrals Methodology

Region	Specialty	Grand Total Payment	Total % In-Network	Inpatient Out-of-Network	Inpatient In-Network	Inpatient % In-Network	Outpatient Out-of-Network	Outpatient In-Network	Outpatient % In-Network	Specialist Out-of-Network	Specialist In-Network	Specialist % In-Network
CENTRAL	CARDIOLOGY											
EASTERN	CARDIOLOGY											
NORTHERN	CARDIOLOGY											
SOUTHERN	CARDIOLOGY											
WESTERN	CARDIOLOGY											
CENTRAL	GASTROENTEROLOGY											
EASTERN	GASTROENTEROLOGY											
NORTHERN	GASTROENTEROLOGY											
SOUTHERN	GASTROENTEROLOGY											
WESTERN	GASTROENTEROLOGY											
CENTRAL	GENERAL SURGERY											
EASTERN	GENERAL SURGERY											
NORTHERN	GENERAL SURGERY											
SOUTHERN	GENERAL SURGERY											
WESTERN	GENERAL SURGERY											
CENTRAL	HEMATOLOGY/ONCOLOGY											
EASTERN	HEMATOLOGY/ONCOLOGY											
NORTHERN	HEMATOLOGY/ONCOLOGY											
SOUTHERN	HEMATOLOGY/ONCOLOGY											
WESTERN	HEMATOLOGY/ONCOLOGY											

Integration by Specialty per Primary Practice with ACO Attributed Lives

Atlantic Health System: Department of Clinical and Business Intelligence



MSSP Practice Integration and Integration by Specialty

Time Period: 20200401-20210331

Using DRG to Specialty Mapping for Inpatient Services and New Referrals Methodology

Region	Practice	Specialty	Specialist Out-of-Network	Specialist In-Network	Specialist % In-Network	Inpatient Out-of-Network	Inpatient In-Network	Inpatient % In-Network	Outpatient Out-of-Network	Outpatient In-Network	Outpatient % In-Network
NORTHERN		CARDIOLOGY									
NORTHERN		GASTROENTEROLOGY									
NORTHERN		GENERAL SURGERY									
NORTHERN		HEMATOLOGY/ONCOLOGY									
NORTHERN		NEPHROLOGY									
NORTHERN		NEUROLOGY									
NORTHERN		NEUROSURGERY									
NORTHERN		ORTHOPEDIC SURGERY									
NORTHERN		PHYSICAL MEDICINE AND REHABILITATION									
NORTHERN		PULMONOLOGY									
NORTHERN		RADIOLOGY - DIAGNOSTIC									
NORTHERN		RHEUMATOLOGY									
NORTHERN		THORACIC SURGERY									
NORTHERN		UROLOGY									
NORTHERN		VASCULAR SURGERY									

Rendering Provider Drilldowns – specialists, outpt and inpt services

Atlantic Health System: Department of Clinical and Business Intelligence
MSSP Specialist/Professional Claims Summary
 Time Period: 20200401-20210331
 Using New Referrals Methodology

Region	Practice	Specialty	Rendering Provider Name	Visited Practice	InNetwork YN	Total Paymen	Number Claims	Unique Patients
WESTERN		PULMONOLOGY			Y	\$20,467	169	56
CENTRAL		GASTROENTEROLOGY			N	\$14,519	117	54
CENTRAL		PHYSICAL MEDICINE AND REHABILITATION			Y	\$22,414	384	51
EASTERN		VASCULAR SURGERY			Y	\$7,607	72	47
NORTHERN		DERMATOLOGY			Y	\$6,516	59	39
CENTRAL		NEUROSURGERY			Y	\$13,632	94	38
CENTRAL		INFECTIOUS DISEASE			Y	\$11,306	92	38
CENTRAL		PHYSICAL MEDICINE AND REHABILITATION			Y	\$8,450	147	38
CENTRAL		INFECTIOUS DISEASE			Y	\$8,628	78	37
EASTERN		GASTROENTEROLOGY			Y	\$7,149	77	37
SOUTHERN		GASTROENTEROLOGY			Y	\$10,298	133	36
CENTRAL		PHYSICAL MEDICINE AND REHABILITATION			Y	\$7,385	132	36
WESTERN		GASTROENTEROLOGY			Y	\$8,046	64	35
SOUTHERN		GASTROENTEROLOGY			Y	\$5,786	55	35
WESTERN		INFECTIOUS DISEASE			Y	\$14,675	149	34
EASTERN		PULMONOLOGY			Y	\$13,870	81	34
CENTRAL		INFECTIOUS DISEASE			Y	\$12,431	103	34
EASTERN		GASTROENTEROLOGY			Y	\$3,513	53	34
CENTRAL		PHYSICAL MEDICINE AND REHABILITATION			N	\$14,703	164	33

Atlantic Health System: Department of Clinical and Business Intelligence
MSSP Outpatient Facility Based Claims Summary
 Time Period: 20200401-20210331
 Using New Referrals Methodology

Region	ACO	Group	Practice	Specialty	Rendering Provider Name	Visited Facility	InNetwork YN	Total Paymen	Number Claims	Unique Patients
CENTRAL	AHS	AMG		CARDIOLOGY			Y	\$15,372	62	43
SOUTHERN	AHS	PCP		GENERAL SURGERY			N	\$1,812	39	39
SOUTHERN	AHS	AMG		GENERAL SURGERY			N	\$1,708	36	36
WESTERN	OPTIMUS	Independent		PULMONOLOGY			Y	\$30,500	309	30
EASTERN	AHS	AMG		CARDIOLOGY			Y	\$25,259	39	26
SOUTHERN	OPTIMUS	Independent		GENERAL SURGERY			N	\$1,162	25	25
CENTRAL	AHS	AMG		HEMATOLOGY/ONCOLOGY			Y	\$48,374	58	20
SOUTHERN	OPTIMUS	Independent		GENERAL SURGERY			N	\$1,767	21	20
SOUTHERN	AHS	AMG		GENERAL SURGERY			N	\$883	19	19
CENTRAL	AHS	AMG		CARDIOLOGY			Y	\$14,093	28	19
NORTHERN	AHS	AMG		CARDIOLOGY			Y	\$11,647	30	18

Integration by Specialist Splitters

Atlantic Health System: Department of Clinical and Business Intelligence

MSSP Population: Splitters Report - Utilization of Medical Facilities by Providers

12 Specialty Categories, Elective Inpatient and Outpatient Procedures, No Transplant Procedures

Timeframe: 2020-04-01 - 2021-03-31

Specialist ACO Affiliation		Provider and Specialty			Provider Splitters				Provider Facility Affiliation and Percent of the Business Pe			
Region	Specialist Practice Name	Rendering Provider Name	Specialty	Provider InNetwork	Total Payme	In-Network	Out-of-Network	% In-Network	Facility 1	F1 % Revenu	Facility 2	F2 % Revenu
SOUTHERN			HEMATOLOGY/ONCOLOGY	N	\$190,945	\$0	\$190,945	0.00%		100.00%		
SOUTHERN			ORTHOPEDIC SURGERY	N	\$94,796	\$104	\$94,691	0.11%		97.04%		2.39%
SOUTHERN			ORTHOPEDIC SURGERY	Y	\$82,841	\$0	\$82,841	0.00%		100.00%		
SOUTHERN			UROLOGY	N	\$81,745	\$125	\$81,620	0.15%		99.46%		0.39%
SOUTHERN			HEMATOLOGY/ONCOLOGY	Y	\$75,197	\$0	\$75,197	0.00%		99.87%		0.13%
SOUTHERN			GENERAL SURGERY	Y	\$69,789	\$0	\$69,789	0.00%		100.00%		
SOUTHERN			CARDIOLOGY	Y	\$61,288	\$0	\$61,288	0.00%		100.00%		
SOUTHERN			GENERAL SURGERY	Y	\$59,918	\$0	\$59,918	0.00%		100.00%		
SOUTHERN			CARDIOLOGY	Y	\$64,192	\$5,419	\$58,774	8.44%		91.56%		8.44%
SOUTHERN			HEMATOLOGY/ONCOLOGY	N	\$47,700	\$0	\$47,700	0.00%		100.00%		
SOUTHERN			GENERAL SURGERY	N	\$46,842	\$0	\$46,842	0.00%		100.00%		
SOUTHERN			HEMATOLOGY/ONCOLOGY	N	\$44,987	\$0	\$44,987	0.00%		72.68%		24.31%
SOUTHERN			GENERAL SURGERY	N	\$43,706	\$317	\$43,389	0.72%		99.28%		0.72%
SOUTHERN			GENERAL SURGERY	N	\$40,169	\$0	\$40,169	0.00%		100.00%		
SOUTHERN			GASTROENTEROLOGY	Y	\$38,177	\$0	\$38,177	0.00%		100.00%		
SOUTHERN			CARDIOLOGY	Y	\$49,766	\$13,519	\$36,247	27.17%		72.83%		27.17%
SOUTHERN			GENERAL SURGERY	Y	\$31,618	\$0	\$31,618	0.00%		100.00%		
SOUTHERN			CARDIOLOGY	Y	\$51,030	\$19,604	\$31,426	38.42%		61.58%		38.42%
SOUTHERN			GASTROENTEROLOGY	Y	\$29,692	\$0	\$29,692	0.00%		100.00%		

Integration at the Primary Care Provider Level



Primary Care Clinical Integration Performance Report

Practice Name

New Referrals, 12 Specialties, Professional Claims w/ CPT Codes: '10004'-'69990','70010'-'79999','90281'-'99607','99091'-'99499'

Time Period: 2020-04-01 - 2021-03-31

Number of Attributed Medicare Members: 382

Specialty	Your Performance	Your Peers (Region)	Your Network (All Regions)	Provider 1	P1 %	Provider 2	P2 %	Provider 3	P3 %
CARDIOLOGY	84	77	60		8.6%		4.3%		4.1%
GASTROENTEROLOGY	87	71	55		16.7%		14.9%		11.7%
GENERAL SURGERY	56	64	47		11.8%		8.6%		5.4%
HEMATOLOGY/ONCOLOGY	86	66	53		7.8%		6.9%		6.7%
NEPHROLOGY	55	63	52		16.5%		9.9%		7.9%
NEUROLOGY	57	48	39		21.6%		13.0%		
NEUROSURGERY	68	69	53		23.1%		12.2%		
ORTHOPEDIC SURGERY	75	58	44		7.6%		6.9%		
PULMONOLOGY	86	77	60		10.5%		8.2%		
THORACIC SURGERY	93	84	68		18.2%		15.0%		
UROLOGY	88	72	56		17.4%		10.2%		
VASCULAR SURGERY	92	87	64		20.2%		13.6%		

Zipcode 07927: Available Specialists within 15 miles by Clinical Network Usage (% CIN Facility):

100.0%
100.0%
99.7%
96.0%
88.3%
100.0%
100.0%
97.6%
91.9%
77.6%
41.8%
31.0%
22.6%

Integration Intel for Specialists

- Primary care practice referral patterns
- Out-of-Network referral volumes / opportunities for integration

Atlantic Health System: Department of Clinical and Business Intelligence
MSSP Practice Integration and Integration by Specialty
 Time Period: 20200401-20210331

Region	Primary Care Practice	Specialty	Grand Total Payment	Total % In-Network	Specialist Out-of-Network	Specialist In-Network	Specialist % In-Network
NORTHERN		CARDIOLOGY	\$385,367	42.33%	\$63,407	\$68,001	51.75%
NORTHERN		CARDIOLOGY	\$354,843	7.65%	\$75,864	\$27,144	26.35%
NORTHERN		CARDIOLOGY	\$330,315	8.28%	\$110,478	\$21,429	16.25%
NORTHERN		CARDIOLOGY	\$269,019	60.33%	\$49,802	\$62,958	55.83%
			\$1,339,544	28.36%	\$299,551	\$179,532	37.47%

Cardiology Practice XYZ

\$59,965

Non-Cardiology XYZ

\$299,551

Total Professional Services Opportunity

80.00%

\$239,641

Summary

- Agile process with end user engagement
- Transparency
- Self-Management vs Prescriptive
- Medical Neighborhood App
- Team Members
 - ACO Leadership, Medical Director 1:1 Performance Meetings
 - ACO Performance Improvement Incentive Program
 - Practice Level and Regional Leadership
 - Business Development, Service Lines

The Compliance of Incentivizing Clinical Integration

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Compliance Considerations

- **Data Sharing**
 - Inside the ACO/DCE
 - Outside the Organization
- **Incentivizing Integration**
 - GPDC Model Participation Agreement
 - Waivers and Safe Harbors
- **Red Flags**
 - Cherry Picking
 - Referrals
 - Communications

Sharing CMS Data Data Usage – Beyond HIPAA

- ❑ Documenting Compliance with CMS Data Usage Requirements
 - Shared Savings Program – still signs a Data Use Agreement (DUA); no longer requires DUA Addendum
 - GPDC Model – separate HIPAA Authorized Disclosure signed in 4i
- ❑ Requirements are largely the same
 - GPDC Model specifically allows for sharing of beneficiary data with any provider in a treatment relationship with the beneficiary
 - Under Shared Savings Program DUA, CMS Data cannot be shared outside of the ACO, ACO Participants or ACO Provider/Suppliers
- ❑ Cell Suppression and de-identified data sharing limits are in place for both (fewer than 11 beneficiaries)

Sharing CMS Data

Derivative vs Aggregate Data

An ACO can share aggregate findings outside the ACO from the CMS Claims and Claims Line Feed files (e.g., emergency department visits rates by county or admission rates by hospital), provided the findings are compliant with the cell suppression and other rules around disclosure of findings in Section 9 of the DUA. Based on this, an ACO could share the following reports:

- ✓ Report showing readmission rates of various SNFs where all sites shown have numerators of more than 10 readmissions.
- ✓ Report profiling various neurology groups' MRI utilization rates, provided each group had a numerator containing more than 10 referrals.
- ✓ Report showing average cost per patient for various home health agencies, provided the average consists of 10 or more patients.
- ✓ Report showing average costs for beneficiaries with a specific diagnoses or billing code.



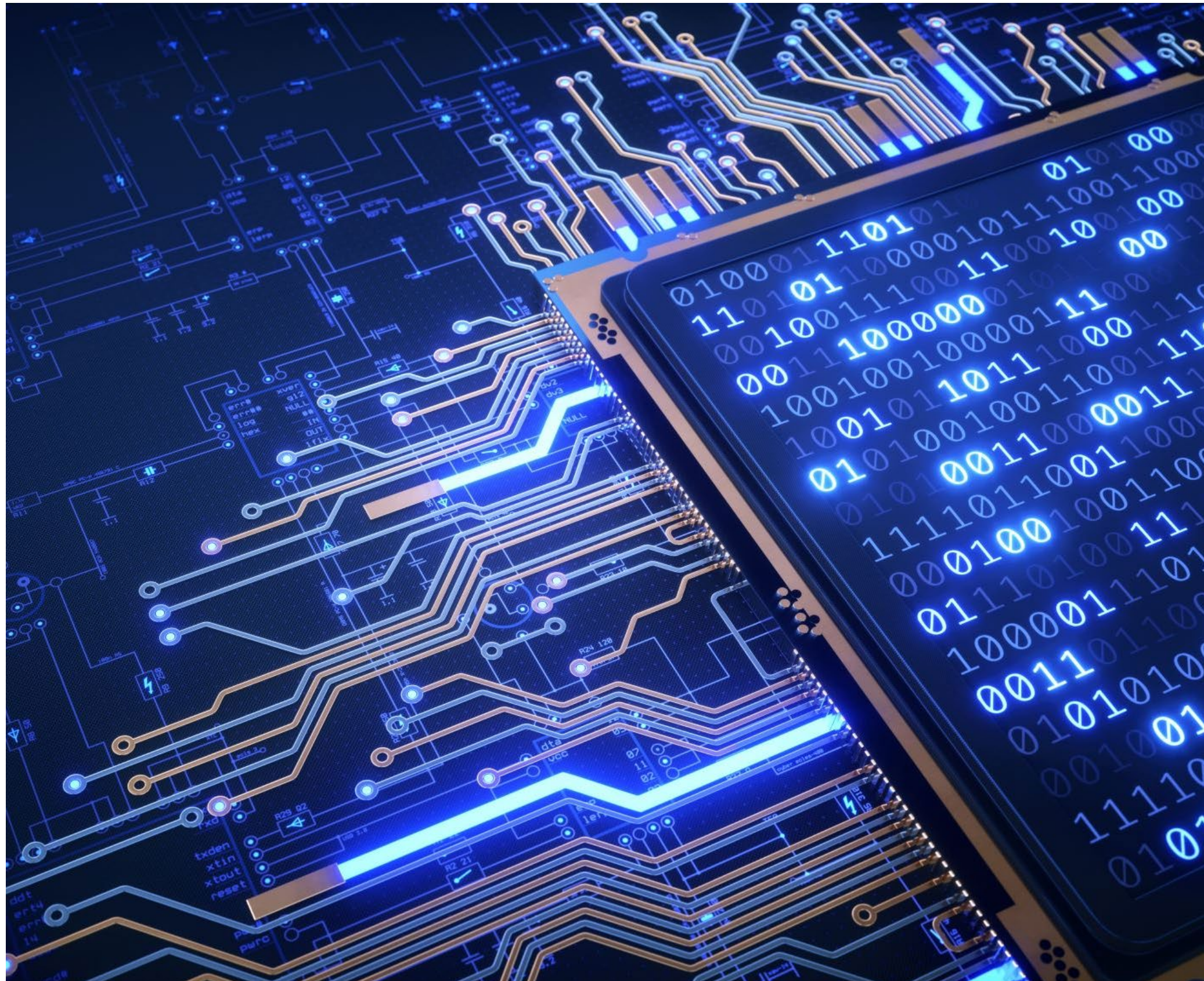
Data Compliance: What You Need to Know

- ❖ The ACO and DCE are responsible for documenting compliance with Data Usage Requirements.
- ❑ **CYA** : Decide how the organization is going to document downstream compliance
 - Should be a discussion between Legal and Compliance:
 - Business Associate Agreements
 - CMS Data Acknowledgement Form
 - Data Logs
- ❑ **CYA** : Detail requirements in the P&Ps
- ❑ **CYA**: Add cell suppression requirements to Marketing Oversight

[Additional Guidance](#) – WRG White Paper: Data Use Agreement Simplification



Incentivizing Integration Providing Software



From the GPDC Model Participation Agreement:

If the arrangement involves the provision of electronic health records software to one or more DC Participant Providers or Preferred Providers, such software shall be interoperable (as defined in 42 C.F.R. § 411.351) or satisfy 42 C.F.R. § 411.357(w)(2) (related to interoperability) at the time it is provided to the recipient.

Incentivizing Integration

MSSP and NextGen FWA Waivers

- ACO Pre-Participation Waiver
- **ACO Participation Waiver**
- Shared Savings Distribution Waiver
- Compliance with Physician Self-Referral (Stark) Law Waiver

None of these waivers apply to similar State laws!



Incentivizing Integration

ACO Participation Waiver

Waives Stark Law, Federal Anti-Kickback Statute and the Gainsharing CMP. This waiver applies broadly to ACO-related arrangements during the term of the ACO's participation agreement, so long as the following are met:

- ACO has entered into a Participation Agreement and remains in good standing
- ACO meets governance, leadership and management requirements
- Governing Body has made and duly authorized a bona fide determination that the arrangement is **reasonably related to the purposes of the MSSP.**

“Purposes of the Shared Savings Program” means:

- Promoting accountability for quality, cost and overall care of Medicare Fee-For-Service Beneficiaries
 - Managing and Coordinating Care through an ACO
 - Encouraging investment in infrastructure and redesigned care processes
- ACO meets documentation & public disclosure requirements



Incentivizing Integration

GPDC Financial Arrangements Safe Harbor

- Must meet all requirements of:
 - GPDC Model PA for Financial Arrangements
 - 42 CFR § 1001.952(ii)(1); **and**
 - Applicable appendices of GPDC Model PA as they relate to Payment Arrangements.

- Does **not** require Governing Body Approval
 - **CYA:** Have Governing Body “reasonably determine” that the incentive will advance one or more goals of the GPDC Model.

- Does **not** require Public Disclosure



Waivers & Safe Harbors: What You Need to Know

- ❑ Use of a waiver or safe harbor does not require CMS approval
 - That's not necessarily a good thing!

- ❑ Bona-fide determination
 - More than a “rubber-stamp”
 - **CYA**: Watch your dates
 - **CYA**: Waiver/Safe Harbor Checklist – capture compliance and approval in one document
 - Records should prove compliance with all elements not just documentation requirements
 - Document how it is “related to the purposes” of the Model
 - Remove financial terms to meet public disclosure requirements

- ❑ Always watch for the *appearance* of Cherry-Picking

- ❑ No State Laws waived



Compliance Red Flags

Cherry Picking

Programs or activities that encourage healthy or low-cost beneficiaries to remain in or receive services from the ACO/DCE or that discourage high risk or high-cost beneficiaries.

Cherry picking may be intentional but could also be an unintended outcome of program or activity. Example: Targeting beneficiaries for Annual Wellness Visit outreach.

Tips to Avoid Cherry Picking

- ✓ Review for *appearance* of impropriety
- ✓ Document *intent* of any new program clearly
- ✓ Be careful when playing the numbers game - use of multiple TINs, splitting ACOs



Compliance Red Flags Referrals

Beneficiary Freedom of Choice is the current pet child of CMS. Be careful that efforts to encourage referrals within the ACO/DCE does not cross the line.

Tips to Avoid Issues around Referrals

- ✓ Ensure P&Ps and Participation Agreement allow for appropriate referrals outside of the ACO/DCE
- ✓ Document *intent* of any new program clearly
- ✓ Be careful when applying incentives to referrals

Compliance Red Flags Communications

MSSP includes provider facing materials in the definition of Marketing Materials requiring CMS approval.

All programs must ensure materials and communications are not misleading:

- ✓ Avoid phrases referring to a Network.
- ✓ Include language specifically allowing referrals to be based on the “medical judgement of the referring physician and the interest and preferences of the beneficiary”.



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