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Clinical Lab 2.0
Initiated Population Health
Jennifer Houlihan, MSP

Clinical Lab 2.0 Workshop
February 27, 2025

Presentation Overview

- **Advocate Overview**

- **Population Health Engagement Examples**

- **Value Based Policy and Payment Update**

- **Questions/Discussion**

Advocate Health Population Health Platform
Managing Health, Quality, and Total Cost of 2.4M Lives and $1.6B in capitated risk

13K+
Participating Physicians

15
ACOs / CINs / Networks

2.4M
Managed Lives

1 of ~7
CMS ACO REACH Health System Participants in the Nation

110+
Value-Based Contracts

$878M
Total CMS/CMMI Taxpayer Savings

$1.4B
Total Value Savings Paid Out

73
Participating Hospitals

Value-Based Care success built-on capabilities fine-tuned over decades of experience managing shared savings, shared risk, professional and global capitation across CMS, commercial and Medicaid contracts.

Network Management

Advanced Analytics

Value Innovation

Clinical Programs

Data Management Infrastructure

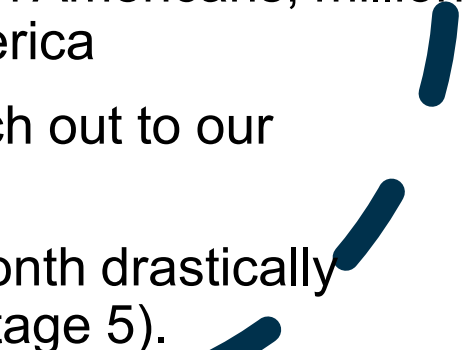**TPA/MSO**

Case Study #1: Chronic Kidney Disease

- Early detection can prevent progression to end-stage kidney disease (ESKD) with need for dialysis or kidney transplantation and extremely high morbidity, mortality, cost

- Heart disease is the major cause of death for those with CKD

- High risk groups include patients with diabetes, hypertension and family history of kidney failure - African Americans (due to the *APOL1* gene), Hispanics, Pacific Islanders, American Indians and Seniors are at greatest risk

- WFUHS owns & operates the nation's largest academic outpatient dialysis program

- WFUHS & Dr. Barry Freedman hold US patent for *APOL1* gene testing – the cause of 35% of ESKD in African Americans, millions more in Africa, the Caribbean and South America

- Commercial MA plans (BCBS, Humana) reach out to our Nephrology leadership daily to control costs

- Diabetic kidney care costs per-patient per-month drastically increases from $1,597 (stage 1) to $6,999 (stage 5).

KidneyIntelx Study

- Nearly $5 million budget shared between WF & Atrium

- Single IRB (WF) with 8 study coordinators (4 in the Triad and 4 in CLT)

- Like an NIH Consortium: screen 10,000 patients in 2 years to enroll 2,000

- Follow-up: 2 visits timed with annual PCP appts (EMR-based follow-up) with updated pharmacy workflow under review

- Current enrollment as of 2/17/203= >800 patients (90% of patients from AHWFB market/6 WFH PCP practices)

- **>70% of patients enrolled in study also in AHWFB Value Based Contracts**
- **>50% also have a medium-high risk eFI score**

| CKD is classified based on: · Cause (C) · GFR (G) · Albuminuria (A)			Albuminuria categories Description and range		
			A1	**A2**	**A3**
			Normal to mildly increased	Moderately increased	Severely increased
			<30 mg/g <3 mg/mmol	30-299 mg/g 3-29 mg/mmol	≥300 mg/g ≥30 mg/mmol
GFR categories (ml/min/1.73m^2) Description and range	**G1**	Normal or high / ≥90	1 if CKD	Treat 1	Refer* 2
	G2	Mildly decreased / 60-89	1 if CKD	Treat 1	Refer* 2
	G3a	Mildly to moderately decreased / 45-59	Treat 1	Treat 2	Refer 3
	G3b	Moderately to severely decreased / 30-44	Treat 2	Treat 3	Refer 3
	G4	Severely decreased / 15-29	Refer* 3	Refer* 3	Refer 4+
	G5	Kidney failure / <15	Refer 4+	Refer 4+	Refer 4+

KidneyIntelX adds
- Plasma TNFR1
- Plasma TNFR2
- Plasma KIM1
- EMR-based variables (including BP, A1c, BMI, insurance status, etc.)

Case Study #2- Use of Frailty as Predictive Risk Score for use in Population Health
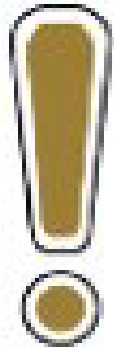
Frailty is a decreased reserve in both physiology and day-to-day function, leading to a vulnerability to acute stressors. This predicts worse health outcomes, including falls, burdensome healthcare utilization, and mortality.

Why eFI? Most frailty tools are time consuming and laborious. The eFI mobilizes routine data that already exists in the electronic health record (EHR), in a single, automated, objective score.

- Frailty predicts a number of outcomes, utilization among them
- Zero additional work to "screen" – it's computed in EMR
- Identify high utilizers before they become high utilizers
- Not disease-specific

Primary Care and Population Health

- eFI identified a significant number of older adults for navigation beyond usual tools (utilization patterns); ↑volume by 25%

- Nurse navigators performed EMR review and patient outreach on all patients with eFI scores $\geq$0.21.

- Navigators assessed:
  - ➢ current clinical status
  - ➢ need for a clinic visit
  - ➢ need for ongoing navigation to address chronic illnesses
  - ➢ connection with community agencies to address SDoH
  - ➢ social isolation

An automatic, passive digital marker for frailty

Elements of eFI: 56 total deficits
- 31 items based on diagnosis codes*
- **20 laboratory measures**
- BP + BMI + smoking*
- 8 functional items from Annual Wellness Visit
- Indicator for Polypharmacy
- Required ≥30 non-missing items
  - ≥9 of 20 laboratory measures

eFI score ranges from 0-1
eFI>0.21 = frailty

Premise:
- Define a universe of aging-related deficits
- **Frailty Index:** What proportion of these deficits does a person have?
- Ranges from 0 to 1
- Typical maximum of ~0.6 to 0.7

eFI is based on 2 year look back period

*Some overlap in items, i.e. glucose and diabetes, BP

Searle *et al.* BMC Geriatrics (2008)
Pajewski…Callahan J Geron A Bio Sci Med Sci (2019)

eFI & Healthcare Utilization

	Mean Cumulative Count (per 100 individuals aged 65+) Over 1 Year		Multiplier
Health Outcome:	"Fit" (eFI<0.1)	"Frail" (eFI>0.21)	
Healthcare Visits	125.5	449.9	3.6
Emergency Department Visits	2.4	19.3	8.0
Hospitalizations	5.1	41.5	8.2
Injurious Falls	0.8	5.1	6.2

Citation: Pajewski N et al. 2019 Journals of Gerontology

Case Study #3 : Ambulatory Pharmacy Services and Initiatives for Diabetes and Hypertension Management

- **Data-Driven and Report-Driven Value-Based Care Work** (built off "healthy planet" rosters in EPIC) to identify patients with hypertension and elevated blood pressures and/or patients with diabetes and elevated A1C values and other quality measure "care gaps"
  - **Managed Medicaid**
    - Focus: care coordination, addressing SDOH, patient education, medication access and adherence
    - 2024 Outreach: 1,304 total patient encounters (1,148 patients had hypertension, 868 patients had diabetes)
  - **Commercial**
    - Focus:, care coordination, medication access and adherence
    - 2024 Outreach: 1,611 total patient encounters (1,455 patients had diabetes, 1, 376 patients had hypertension)
  - **Medicare Advantage**
    - Focus: Triple-weighted medication adherence measures, Statin-Use measures, and DM and BP control
    - 2024 Outreach: 5,836 total patient encounters
  - **Employee Health Plan/One-on-One Rx**
    - Focus: comprehensive mediation reviews for beneficiaries, medication access, optimizing medication therapies and preventive care plans
    - 2024 Outreach: 4,344 total patient encounters (642 of the patient encounters were related to hypertension and 1,163 of the patient encounters were related to diabetes)

Value Based Payment Policy – Last 10 Years

Strong Bipartisan Support for VBP Adoption, though Model Priorities and Messaging Differ Across Administrations

Obama	Trump		Biden
2016 Priorities *(Burwell & Conway)*	**2017 Priorities** *(Price & Conway)*	**2018-2020 Priorities** *(Azar & Boehler)*	**2021-2024 Priorities** *(Becerra & Fowler)*
• Implementing models • Monitoring & optimizing results • Evaluating & scaling models • Integrating innovation across CMS • Analyzing gaps in innovation model portfolio to inform future model development	• Reducing administrative & regulatory burdens • Increasing focus on voluntary models • Seeking industry-driven innovations • Promoting provider choice and competition • Eliminating unsuccessful models	Introducing "**bold, new models**" focused on "4 Ps": • Incentivizing and enabling <u>Physicians</u> to be accountable navigators • Tying <u>Payment</u> to outcomes • <u>Patients</u> as empowered consumers • <u>Preventing</u> disease before it occurs incorporating SDOH	• Incorporate health equity provisions into all new and existing models • Engage safety net providers in APMs • Advance specialist participation in value-based care • Address model overlap issues and drive alignment across programs and payers, particularly with Medicare and Medicaid
Tie **30% of all Medicare provider payments to value** through APMs **by end of 2016** *(achieved March 2016)*; **50% by 2018**.	Redacted Obama-era goals and replaced with HCP-LAN ambitious adoption targets across payer types. **By 2025, shift 100% of Medicare** (Traditional and MA) and **50% of Medicaid and commercial payments to downside risk models** (i.e., LAN Categories 3B and 4).		Move **100% of Medicare beneficiaries** and the vast **majority of Medicaid** enrollees into **accountable care relationships by 2030.**

Each Administration sets bold goals for APM adoption

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CMMI 2.0- *Potential Focus Areas/Models*

Advanced APMs

- Regional- geo direct contracting model
- High Needs focus
- Extension of Kidney Care Choices Model

Make America Healthy Again

- Prevention focus
- Expansion of remote patient monitoring/wearables
- Food as Medicine

Specialty Care Integration

- Alternatives to FFS for longitudinal/ chronic disease care
- Advanced bundles for oncology, cardiology, and orthopedics

MA Growth/APM Incentive in MA Plans

- Incentives in STARS measures
- Medicare Advantage as alternative to traditional Medicare
- Increased focus on the dually eligible

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How the CMS Innovation Center is
SUPPORTING CARE FOR CHRONIC KIDNEY DISEASE

People living with chronic kidney disease face distinct challenges and barriers to care at different stages of their condition. The Innovation Center is testing kidney models (pilot programs) to improve the care experience at every stage and advance health equity.
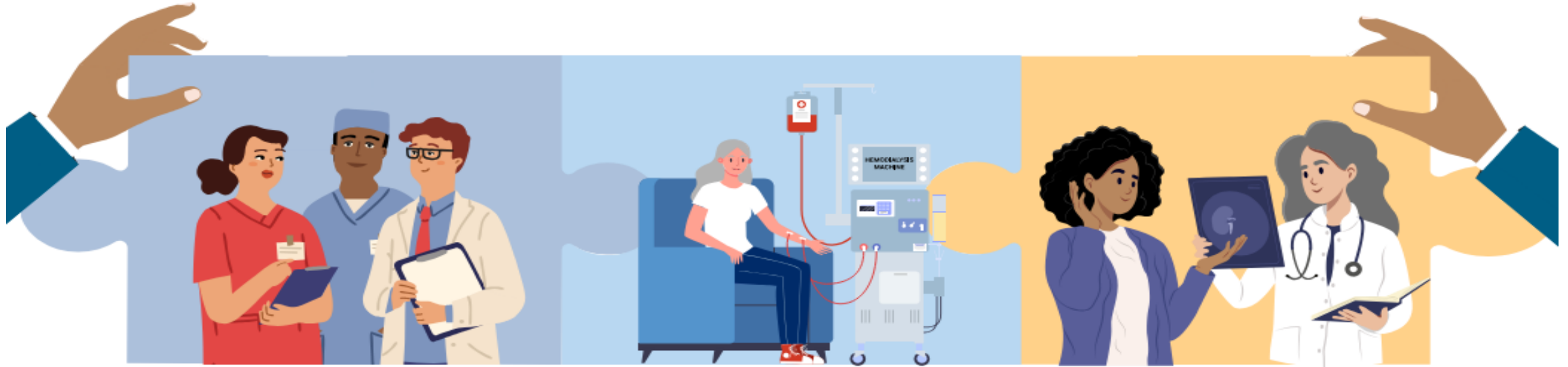
Kidney Care Choices (KCC) Model

► Coordinates care to **delay the onset of dialysis**.

► **Organizes groups of kidney care providers to offer seamless chronic kidney disease care –** including dialysis, transplant, and if appropriate, end-of-life care.

► **Voluntary** model.

End-Stage Renal Disease (ESRD) Treatment Choices (ETC) Model

► **Encourages the use of home dialysis and kidney transplantation** to improve independence and health.

► Prompts dialysis facilities and doctors to offer individuals **education to support their treatment choice.**

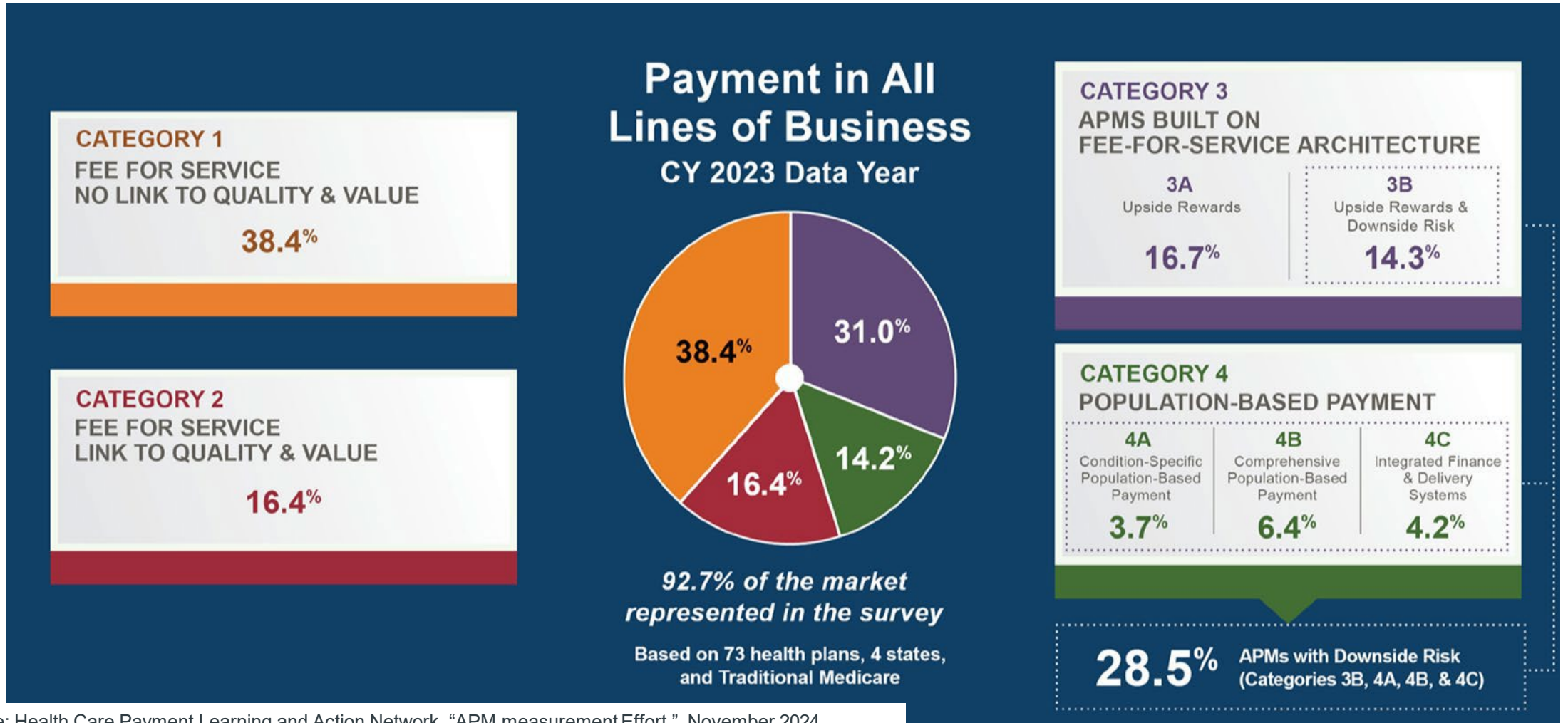► **Mandatory** model.

Increasing Organ Transplant Access Model

► Proposed model would aim to **increase access to kidney transplantation** and the number of kidney transplants to improve health outcomes.

► Designed to focus on **better care coordination** for individuals on the kidney transplant waitlist.

► **Proposed mandatory** model.

HCP-LAN Alternative Payment Model (APM) Framework

CATEGORY 1	CATEGORY 2	CATEGORY 3	CATEGORY 4
FEE FOR SERVICE – NO LINK TO QUALITY & VALUE	FEE FOR SERVICE – LINK TO QUALITY & VALUE	APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE	POPULATION – BASED PAYMENT
	A	**A**	**A**
	Foundational Payments for Infrastructure & Operations (e.g., care coordination fees and payments for HIT investments)	**APMs with Shared Savings** (e.g., shared savings with upside risk only)	**Condition-Specific Population-Based Payment** (e.g., per member per month payments, payments for specialty services, such as oncology or mental health)
	B	**B**	**B**
	Pay for Reporting (e.g., bonuses for reporting data or penalties for not reporting data)	**APMs with Shared Savings and Downside Risk** (e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk)	**Comprehensive Population-Based Payment** (e.g., global budgets or full/percent of premium payments)
	C		**C**
	Pay-for-Performance (e.g., bonuses for quality performance)		**Integrated Finance & Delivery System** (e.g., global budgets or full/percent of premium payments in integrated systems)
		3N Risk Based Payments NOT Linked to Quality	**4N** Capitated Payments NOT Linked to Quality

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1. Health Care Payment Learning & Action Network (HCP-LAN). APM Framework White Paper. 2017.

VBC Impact on US Healthcare Payments

In 2023, 62% of U.S. health care payments included adjustments for Quality & Value and 28.5% had both upside & downside (2-tailed) risk for Providers

1.   Kaufman Hall. VBC Landscape Update. February 2025.

Promising Areas for Specialty Condition Models

- **Musculoskeletal Condition Management Integrated with Specialist Care**
  - Degenerative Joint Disease and Lower Back Pain

- **Longitudinal Cardiology Team Care with Specialist Co-Management**
  - Congestive Heart Failure (including nested bundles for major procedures and admissions for CHF complications)
  - Ischemic Heart Disease (including nested bundles for major cardiac procedures)
  - Conduction Disorders (Atrial Fibrillation; arrhythmias; heart blockages)

- **Dementia/Alzheimer's Disease Longitudinal Coordinated Care Models**

- **Crohn's Disease and Ulcerative Colitis Longitudinal Care Models**

1. Dr. Mark McLelland. *Opportunities for Integrating Specialty Care Within Population-Based Payment Models*. Presentation to PTAC. Duke Margolis Center for Health Policy. March 2, 2023.

Duke | **MARGOLIS CENTER** *for* **Health Policy**

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Policy Lever: Reimbursement Models That Support Preemptive Diagnostics

Medicare and Medicaid Innovation: Expanding reimbursement for lab tests that facilitate early detection of disease, such as predictive genetic testing, liquid biopsies for cancer, and advanced lipid panels for cardiovascular risk assessment.

Preventive Care Bundles: Including high-value lab tests within preventive care bundles or primary care capitation models to support early intervention efforts.

Slido: What data or evidence do payers need to justify higher reimbursement rates for early diagnostic testing?

A) **Cost savings analysis** – Demonstrating reduced downstream healthcare costs (e.g., fewer hospitalizations, lower medication costs).

B) **Clinical outcome improvements** – Data showing better patient outcomes, such as earlier disease detection and improved treatment effectiveness.

C) **Utilization impact** – Evidence that early diagnostics lead to appropriate follow-up care rather than unnecessary testing or procedures.

D) **Comparative effectiveness studies** – Research comparing preemptive diagnostics to standard diagnostic pathways in terms of accuracy, cost, and outcomes.

E) **Patient engagement & adherence data** – Showing that early testing increases patient engagement, compliance with treatment plans, and long-term health benefits.

Policy Lever: Value-Based Contracts Incentivizing Lab-Facilitated Risk Reduction

Lab-Inclusive ACO and MA Contracts: Ensuring accountable care organizations (ACOs) and Medicare Advantage (MA) plans incorporate lab data as part of risk-adjustment and performance metrics.

Performance-Based Incentives: Aligning provider payments with lab-driven population health goals, such as reducing preventable hospitalizations through early biomarker detection.

Chronic Disease Management Programs: Incentivizing the use of lab diagnostics in managing conditions like diabetes, cardiovascular disease, and chronic kidney disease by integrating lab results into care pathways that lower overall cost of care.

Slido: Are you currently involved in value-based contracts that incorporate lab data for risk stratification? Yes/No

Policy Lever Coverage Expansion for Biomarker-Driven Care Models

Medicare & Medicaid Policy Changes: Expanding coverage for biomarker testing to support precision medicine approaches, particularly for oncology, neurology (e.g., Alzheimer's disease), and rare diseases.

Private Payer Alignment: Advocating for commercial insurers to cover broader biomarker panels beyond standard-of-care guidelines, ensuring better patient stratification and personalized treatment.

State-Level Initiatives: Encouraging state Medicaid programs to reimburse biomarker testing for early intervention and treatment planning, reducing disparities in access.

Slido: Which payer segment should be prioritized? A: Medicare, Medicare Advantage, Commercial, Employer or Medicaid?

Wrap- Up- Opportunities to Partner with Population Health

1. Data Analysis and Reporting

Identify high-risk groups: Analyze lab data to identify populations with elevated risk factors for specific diseases based on demographics like age, ethnicity, socioeconomic status, and geographic location.

Risk stratification: Utilize data to stratify patients into risk categories, allowing for prioritized outreach and preventive care.

2. Proactive Screening and Early Detection:

Targeted screening programs: Develop and implement targeted screening programs for specific populations based on identified risk factors with lab team.

Reminder systems: Utilize patient data to send timely reminders for necessary screenings and follow-ups

3. Care Coordination and Intervention

Clinical decision support: Integrate lab results into electronic health records (EHRs) with clinical decision support tools to guide provider decision-making and care management resourcing.

4. Addressing Social Determinants of Health

Social needs screening: Incorporate social needs screening questions into lab requisition process to identify patients facing barriers to care.

Comparison of MLRs by Organization for 2023 to 2024

Organizations (top to bottom): Cigna Group, UnitedHealth Group, Centene, Elevance Health, Humana, CVS Health

X-axis: 7... 82% 84% 86% 88% 90% 92% 94%
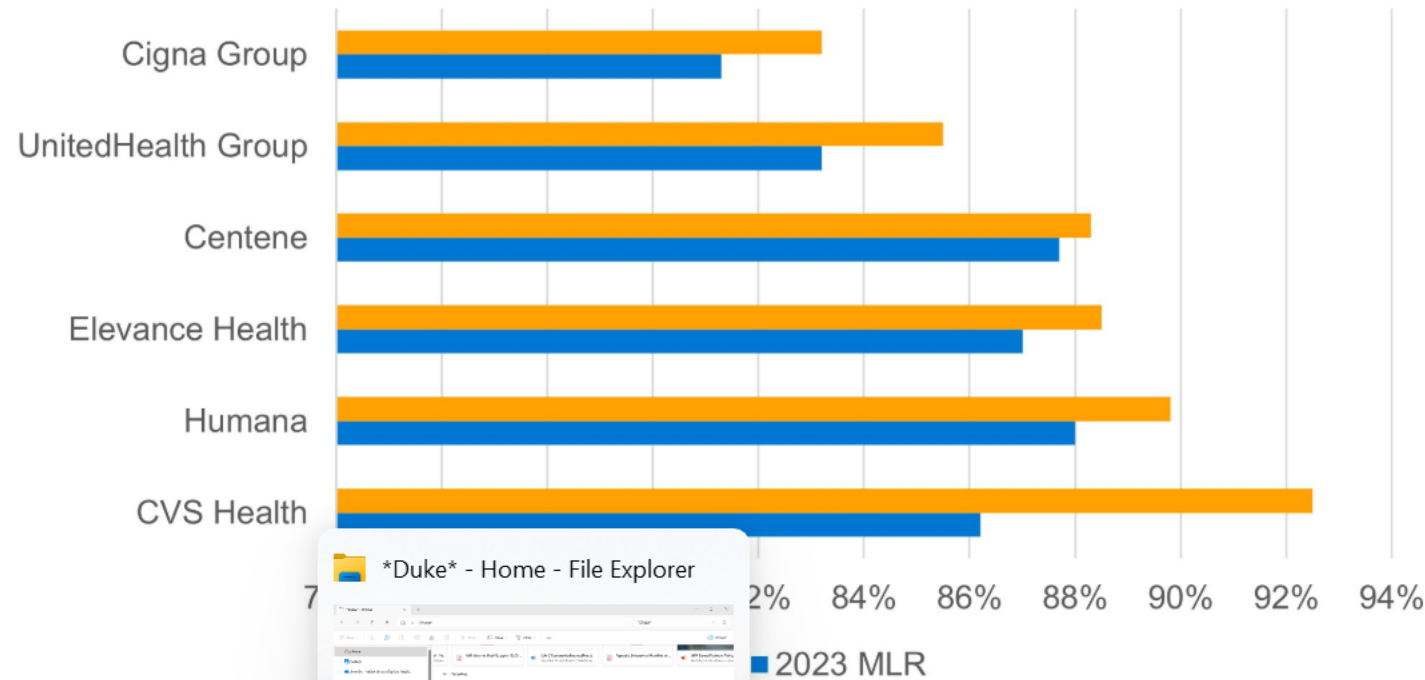
Legend: 2023 MLR

Julia Friedman • Following
Principal and Consulting Actuary | Healthcare ...
1w • 🌐

Becker's Payer did a nice job consolidating some of the national player organizations reported MLRs in 2024 and compared them to 2023. I thought it might be helpful to graph this information since I'm a more visual learner. 📊

Can we find a common theme on the 2024 MLR increases across organizations with respect to #medicareadvantage? Keep in mind, these reported MLRs are not all tied to #medicareadvantage business. In reading the quotes below (in the comments due to character limits...), the following stuck out to me, and hopefully none of these come as a surprise:

▶ Elevated trend levels, both medical and Rx ...more

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