touchpoints

Connecting you to the Heritage Provider Network

HERITAGE PROVIDER NETWORK | Fall 2018, Issue 33

Contents

4

FEATURE STORY

qHMO: Brings Cutting-Edge Automation

17

*touch*points

FALL 2018
ISSUE 33

Comments? Questions?
Go to "Contact Us" at the bottom of every page on heritageprovidernetwork.com

VIEW THE DIGITAL EDITION

Now you can access *TouchPoints* whenever and wherever you want by visiting RegalMed.com/News-Events

Crossroads

with Dr. Richard Merkin

Dr. Merkin's unique perspective as Innovation, Technology, Legislation and Care Delivery come together to impact the future of population health.

Innovation and Technology Builds Stronger Infrastructures Around Patient-Driven Care

As a healthcare organization, our peers and colleagues often measure our success by how well we deliver quality care to our member population. How do we define quality care within the limits of our own infrastructure? Do we rely solely on the feedback we receive about the care and services we provide, or how well we maintain our compliance and best practices, processes and procedures to uphold our reputation

Our proactive approach to fostering innovation and invention is what motivates us to find solutions ...

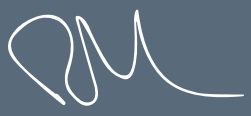
for being one of the best in our industry? Perhaps the answer lies deep within the very core of our business in the ways we take care of our members. We must carefully examine both the internal and external factors that can potentially influence their wellness and overall physical, behavioral and emotional well-being. Only then can we truly give meaning to our definition of quality care.

At Heritage Provider Network (HPN), we cannot wait for business solutions and care delivery to be built by someone else. Our proactive approach to fostering innovation and invention is what motivates us to find solutions to solve the common and unique conditions that significantly affect the health of our members.

With the help of HPN's development team, with the implementation of qHMO and the mobile application, we ensure that our focus aligns with innovating medicine and science while maintaining the profound connection we have with our members, their families and their loved ones. The invaluable and quantifiable data gathered from qHMO is shared and utilized successfully throughout our affiliate medical groups to enhance our ability to support care delivery much more effectively and efficiently.

Collection of information from our patient population is essential for preventive care, disease prevention, and treating chronic conditions, in addition to providing optimal acute care to members. Data sharing also helps our organization avoid consequences of opioid misuse by adhering to best practices and compliance, rules and regulations — all the aspects that help to govern and maintain the integrity of our healthcare business.

Our continued focus on innovation and technology by building a solid data-driven infrastructure will help us move forward in the business of population health as we dedicate our resources to help transform the lives of our members for generations to come.



Richard Merkin, M.D.
President and CEO of HPN

Richard Merkin, M.D.
Healthcare visionary, Dr. Richard Merkin, has spent the last 40 years implementing a successful, workable business model to address the needs and challenges of affordable managed healthcare.

qHMO BRINGS CUTTING-EDGE AUTOMATION

TO ENHANCE PATIENT CARE AND DELIVERY

During our in-depth interview with the Heritage Provider Network (HPN) qHMO team, we discovered the many ways this technology and application are helping to bring automation and uniformity to enhance and deliver quality care utilization among physicians and healthcare professionals across the healthcare spectrum. The dedicated team responsible for this innovation development and design speaks to its features and functionality to highlight the many benefits of qHMO and its goal to streamline processes across HPN and its affiliates, thus creating improved and expedited information sharing and capturing to bring patient experience to a completely new level.

Q: When did you first realize there was a need to develop an in-house population health technological solution?

A: In 2003, the purpose was to manage CMS risk adjustment for the Medicare Advantage population, as there were no other products available in the marketplace. Since then, the Heritage team has been developing in-house applications to streamline processes, such as Quality Measures, Care Management, and standardized financial reporting. As Heritage's membership grew substantially, and on-boarded additional lines of business in the wake of the Accountable Care Act in 2012, the organization faced new challenges and regulatory requirements in the realm of population health management. The healthcare industry has long focused on event-based care, which reflects a lack of patient-centered, coordinated care approach among the popular EMR systems. The existing products in the marketplace did not meet the requirements for population health and holistic care management, and therefore, we expanded and enhanced our existing in-house applications. The application meets all regulatory and health plan requirements, and is NCQA certified.

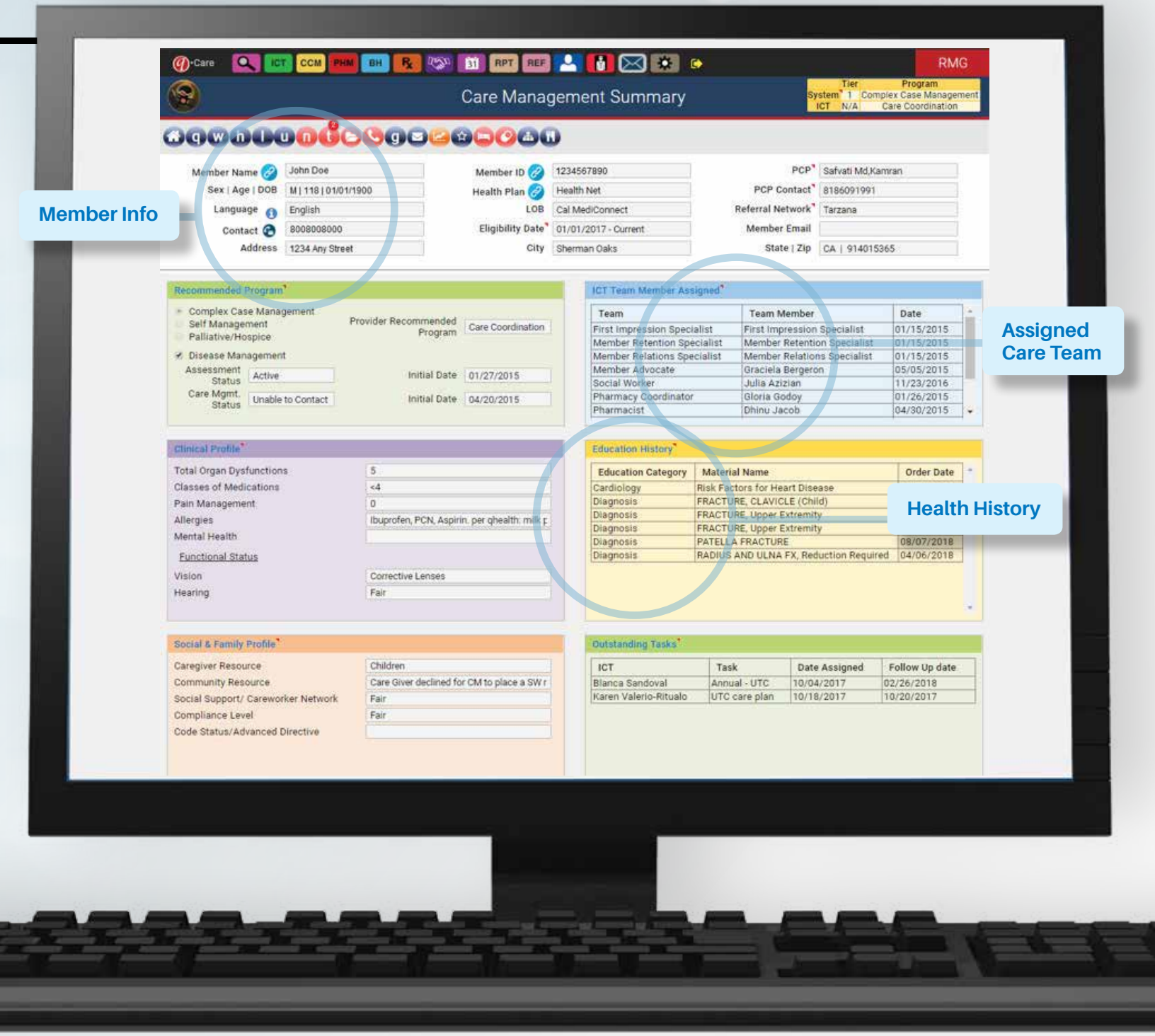
Q: How did you approach building what is now called "qHMO"?

A: Our goal was to improve our ability to serve our patients by using technology to increase our healthcare team's efficiency. We enabled the organization to direct resources toward actual delivery of care. This includes empowering all stakeholders with aggregated and meaningful information about the patients, in an intuitive and easily accessible manner, enabling them to provide care in a coordinated and collaborative manner.

Q: How does your team determine which enhancements to launch, and when?

A: The q. development and enhancement cycle is unique and more frequent compared to any

The Heritage team had been developing in-house applications to streamline processes such as Quality Measures, Care Management, and standardized financial reporting.



application of its size. The application is typically updated with new releases twice a week to ensure that new features are made available to the users as soon as it becomes available. The end-users play an integral part in requesting enhancements that help automate their processes, and/or assist in meeting regulatory requirements. The Heritage team conducts and attends meetings both at the Heritage level, and in individual group settings to understand users' requirements. The requirements are then evaluated and optimized workflows are created to finalize the enhancement. Based on overall clinical, financial and regulatory impact, a priority is assigned to each enhancement.

Q: What are the key features of qHMO that help to streamline population health?

A: q. has comprehensive disease registries, which are created, using data from claims, lab and pharmacy that is fully integrated into the application. The registries are "transparent" as they provide detailed criteria, which qualify a

One of the most innovative features is learning through gamification (q.Jack). In addition to improving user engagement, it provides educational training to the users.

member to be part of the registry. When managing a member in a particular registry, all the comorbidities are made available so they are addressed at the same time to provide holistic care.

For each disease registry, the application has national clinical guidelines (detailed and summarized) and treatment algorithms to educate clinical staff in setting goals and managing the disease conditions. The application also provides disease specific patient education and dietary education materials from nationally recognized vendors.

In addition to population health management registries, the application uses a comprehensive algorithm for risk stratification to identify members who have the highest acuity and therefore qualify for complex case management.

Q: What is the team's structure and responsibilities?

A: In addition to the regular functions handled by the Heritage team, the team also manages the software development lifecycle. We follow the industry practices for obtaining user requirements, planning, designing, developing the code, testing and releasing the update. Different team members are involved at different stages of the development cycle. There is always a senior team member who oversees the development and deployment of an enhancement. In addition, all enhancements are reviewed and approved by Jaya Kurian, CFO,

Pictured below from left to right: *1st row:* Anshul Rawat, Mia Wang, Scarlett Zhao, Liwei Chiang. *2nd row:* Arunima Prasad, Joy Orosky, Frank Asi, Richard Jester, Abhay Chauhan, Neha Yadav. *3rd row:* Rini Jose, Natjaya Chinda, Jaya Kurian, Mihir Shah, Kevin Ding, Carrie Dian, Jubil Sason. *4th row:* Rajat Malhotra, Mihir Sanghavi, Stanley Yan, Scott Bae, Mitun George, Ali Suzon, Lindra Frandinata. *5th row:* Maciej Makowiecki, Patrick Peng, Sachin Vighe, Gautam Machingal, Chenlei Zhao, Jeffry Rijadi, Shantaram Parab. *Team members not pictured:* Candice Chen, Cynthia Zhang, Greshe Abraham, Neil Zhang, Sandra D'Lopez, Than Aye, Octavio Campos, Rajeev Jacob

Heritage Provider Network, along with other senior team members.

Q: How do you maintain the servers in the back end?

A: The q. application is offered as a hybrid Software as a Service (SaaS), where the physical servers (hardware) are maintained by the groups' IT teams, and the remaining aspects of the servers such as the databases, web applications, documents, etc. are managed by the Heritage team. There is a high level of automation on the servers to ensure that integrated processes, interfaces, and jobs run smoothly.

Q: What is the most innovative feature of qHMO?

A: One of the most innovative features is learning through gamification (q.Jack). In addition to improving user engagement, it provides educational training to the users. Based on our users' feedback, the best feature of the application is the aggregation of member's healthcare data, meaningfully organized and presented concisely.

Q: What does the future hold for qHMO?

A: We are currently working toward implementing e-prescribing and building an HR portal for Employee Management.

Q: What is the mobile app and how does it fit within qHMO?

A: q. mobile app allows members to connect and communicate with their assigned Interdisciplinary Care Team (ICT). The ICT members can view and respond to messages from members using q.HMO or the mobile app.

qHMO login page listing the various portals available to access.

Mobile app utilizes data from q.HMO to display the member's health history, care plan goals, view medications and make appointments with their ICT.

Q: What is the goal of the mobile app?

A: The primary goal for the mobile app is to improve member experience and outcomes by:

- Connecting the members with their healthcare data, and their care teams
- Encouraging member compliance with programs like Complex Case Management, HealthTraq (home monitoring) etc. for which they are enrolled

Q: What are the features of the mobile app?

A: Some of the features of the mobile app:

- Members have the ability to communicate with their Provider/ICT via HIPAA compliant secure messaging
- Displays member summary, care plan, medication reconciliation, disease management sections, laboratory, and pharmacy history
- Provides the ability to easily locate nearby urgent care centers, which are star rated, based on available services. The user can see a Google street view of the facility and get driving directions.

Q: What is the future of the mobile app?

A: We are currently working on implementing Televisit via video conference.

Scott Bae, VP, Corporate Information Systems, adds, "Each member of the qHMO team performs many other responsibilities within the department. The q application is just a fraction of their daily tasks. We work very closely and cohesively so that anything that is requested of a team member, no matter how large or small, is performed willingly to achieve a single goal, which plays a pivotal role in its success."

The success of qHMO and the mobile app will inspire greater collaboration and improved healthcare delivery as it becomes more widely utilized. It will transcend all levels of healthcare management, setting the bar for quality and efficiency, influencing daily operations across all medical groups and affiliates.

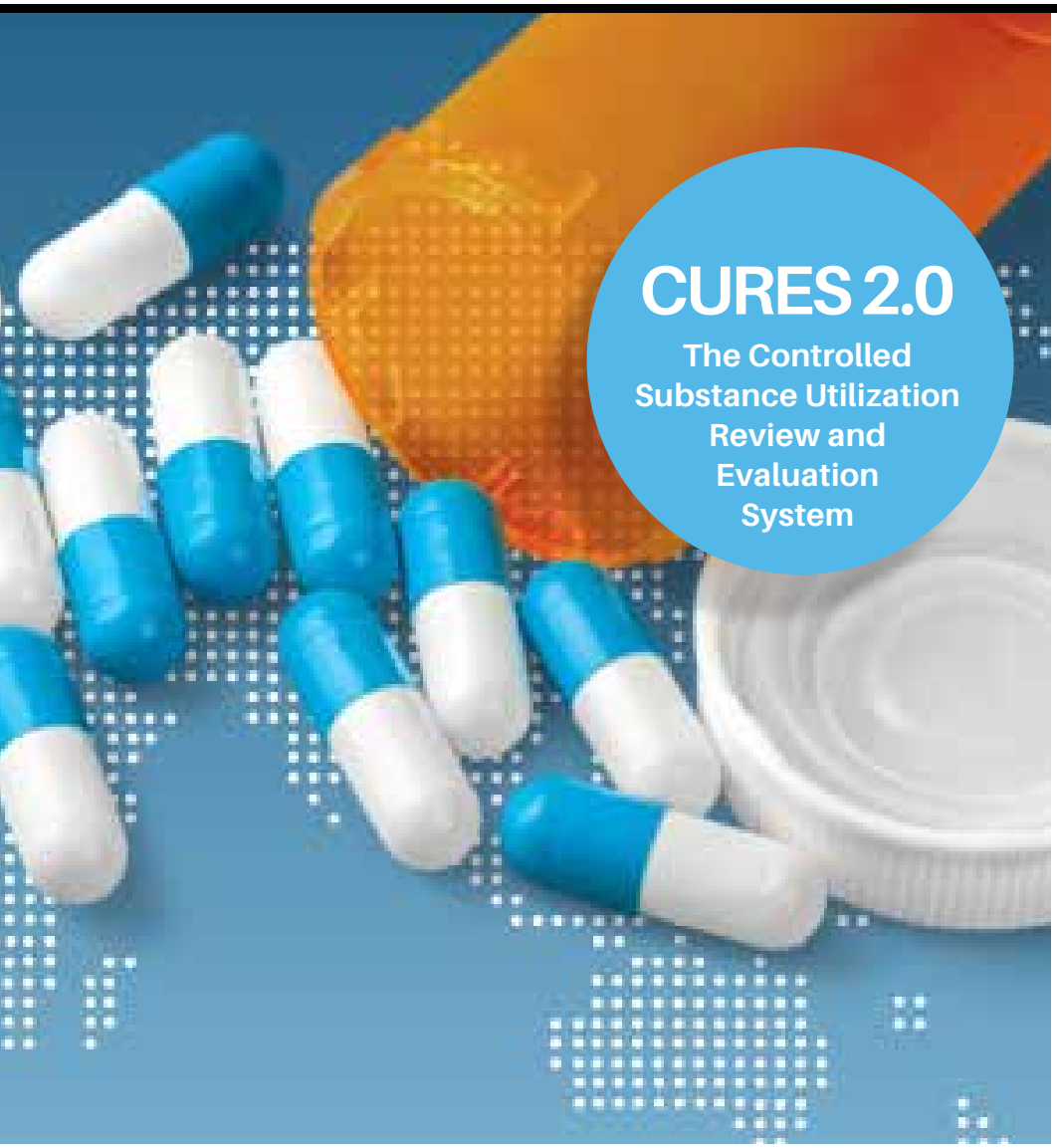
A Physician's Responsibility: Compliance, CURES and Fighting the War Against Opioid Addiction

"IT'S ABOUT ETHICS AND DOING THE RIGHT THING"

Over the years, the increasing amount of narcotics and anxiety drugs being prescribed to patients has grown to an alarming rate that the Centers for Medicare and Medicaid Services (CMS) and various other bodies of government have implemented more strict rules to govern and mitigate the problem. Its main goal is to ensure that physicians do not overprescribe opioids, which can lead to severe misuse that inevitably becomes the gateway to committing fraud. As a nation, we have reached a point where overprescribing of antibiotics are a secondary concern. Today, opioids have taken its place to raise an even greater national concern.

According to the National Institute of Health on Drug Abuse (NIH), the misuse of and addiction to opioids — including prescription pain relievers, heroin, and synthetic opioids such as fentanyl — is a serious national crisis that affects public health as well as social and economic welfare. It accounts for more than 115 deaths per day from overdosing on opioids. The Centers for Disease Control and Prevention (CDC) estimates that the total burden on the U.S. economy alone from prescription opioid misuse is $78.5 billion a year. This includes the costs of healthcare, addiction treatment, lost productivity, and criminal justice involvement.

The fight against opioid abuse affects everyone — physicians, the fraud department and other departments who have to perform their due diligence to monitor and take necessary action when such illegal activities occur. In the last five years since Jeff Baron, Compliance Officer & Privacy Officer – VP of Compliance, joined Regal, Lakeside and ADOC Medical Groups, affiliates of Heritage Provider Network, he has seen instances where patients have taken counterfeit prescriptions to their pharmacist hoping to get opioids, or attempt to change the information



to increase the original amount prescribed. "We have not been hit as hard as other organizations, but the consequences from these actions impact all of our providers," says Jeff.

As technology improves, our organization along with government agencies will have greater access to better and more foolproof methods to deter such crimes. Due to the increasing pressure and urgency to prevent opioid abuse, healthcare organizations like Regal, Lakeside and ADOC Medical Groups, must also increase their methods to validate the amount of medications being prescribed by their physicians. In 2016, the Department of Justice (DOJ) released CURES 2.0. The Controlled Substance Utilization Review and Evaluation System (CURES) mandates that physicians are required to pull all relevant medical records and history before medication is prescribed. CURES 2.0 significantly improved the user experience and increased functionality to allow physicians or staff members with authorization to run patient report queries for access by prescribers, pharmacies, and other dispensers, enable improved communication with other physicians and receive patient alerts.

Jeff adds, "The information from reports provides a more accurate account of the patient's history so that we can determine if they have previously gone to an urgent care, for example, and received medication, or if they have been prescribed medication elsewhere. Our physicians, as well as our entire organization, have a professional obligation to validate the integrity of the prescriptions before it reaches the patient."

When certain patients trigger suspicion of overusing or underusing their prescription, they are referred to a pain management specialist to determine if there is a valid need for continuing medication, or find a more suitable method to treat the underlying causes of the patient's pain. Over the years, patients have found a way to abuse the system by "doctor shopping" — hopping from one physician to the next hoping to receive a new prescription for the same medication.

As an organization, it's imperative to prevent abuse at all cost by collaborating with the pharmacy department, staff physicians and the federal government. Only by working together can we begin to make a positive impact on the fight to win the war against opioid misuse and help patients to discover safer and healthier lifestyles.

CMS' IMPORTANT CHANGES TO MEDICARE AIMED TO IMPROVE THE DOCTOR-PATIENT RELATIONSHIP

Proposed changes to the Medicare Physician Fee Schedule and Quality Payment Program would streamline clinician billing and expand access to high-quality care

On July 12, 2018, the Centers for Medicare & Medicaid Services (CMS) proposed historic changes that would increase the amount of time that doctors and other clinicians can spend with their patients by reducing the burden of paperwork that clinicians face when billing Medicare. The proposed rules would fundamentally improve the nation's healthcare system and help restore the doctor-patient relationship by empowering clinicians to use their electronic health records (EHRs) to document clinically meaningful information, instead of information that is only for billing purposes.

"Today's proposals deliver on the pledge to put patients over paperwork by enabling doctors to spend more time with their patients."
~ Seema Verma

"Today's reforms proposed by CMS bring us one step closer to a modern healthcare system that delivers better care for Americans at a lower cost," said HHS Secretary Alex Azar. "Such a system requires empowering American patients by giving them price and quality transparency and control over their own interoperable health records, goals supported by CMS's proposals. These proposals will also advance the successful Medicare Advantage program and accomplish a historic regulatory rollback to help physicians put patients over paperwork. Further, today's proposed reforms to how CMS pays for medicine demonstrate the commitment of HHS to implementing President Trump's blueprint for lowering drug prices. The ambitious reforms proposed by CMS under Administrator Verma will help deliver on two HHS priorities: creating a value-based healthcare system for the 21st century and making prescription drugs more affordable."

"Today's proposals deliver on the pledge to put patients over paperwork by enabling doctors to spend more time with their patients," said CMS

Administrator Seema Verma. "Physicians tell us they continue to struggle with excessive regulatory requirements and unnecessary paperwork that steal time from patient care. This Administration has listened and is taking action. The proposed changes to the Physician Fee Schedule and Quality Payment Program address those problems head-on, by streamlining documentation requirements to focus on patient care and by modernizing payment policies so seniors and others covered by Medicare can take advantage of the latest technologies to get the quality care they need."

The proposals, part of the Physician Fee Schedule (PFS) and the Quality Payment Program (QPP), would also modernize Medicare payment policies to promote access to virtual care, saving Medicare beneficiaries time and money while improving their access to high quality services no matter where they live. Such changes would establish Medicare payment for when beneficiaries connect with their doctor virtually using telecommunications technology (e.g., audio or video applications) to determine whether they need an in-person visit. Additionally, the QPP proposal would make changes to quality reporting requirements to focus on measures that most significantly impact health outcomes. The proposed changes would also encourage information sharing among healthcare providers electronically, so patients can see various medical professionals according to their needs while knowing that their updated medical records will follow them through the healthcare system. The QPP proposal would make important changes to the Merit-based Incentive Payment System (MIPS) "Promoting Interoperability" performance category to support greater EHR interoperability and patient access to their health information, as well as to align this clinician program with the proposed new "Promoting Interoperability" program for hospitals.

If today's proposals were finalized, clinicians would see a significant increase in productivity – leading to substantially more and better care provided to their patients. Removing unnecessary paperwork requirements through the PFS proposal would save individual clinicians an estimated 51 hours per year if 40 percent of their patients are in Medicare. Changes in the QPP proposal would collectively save clinicians an estimated 29,305 hours and approximately $2.6 million in reduced administrative costs in CY 2019.

Changes in the QPP proposal would collectively save clinicians an estimated 29,305 hours and approximately $2.6 million in reduced administrative costs in CY 2019.

Proposed CY 2019 Physician Fee Schedule Key Changes

The Physician Fee Schedule establishes payment for physicians and medical professionals treating Medicare patients. It is updated annually to make changes to payment policies, payment rates and quality-related provisions. Extensive public feedback the agency has received has highlighted a need to streamline documentation requirements for physician services known as "evaluation and management" (E&M) visits, as well as a need to support greater access to care using telecommunications technology.

The proposed changes to the Physician Fee Schedule would reinforce CMS' Patients Over Paperwork initiative focused on reducing administrative burden while improving care coordination, health outcomes, and patients' ability to make decisions about their own care.

Streamlining Evaluation and Management (E&M) Payment and Reducing Clinician Burden

CMS and the Office of the National Coordinator for Health Information Technology (ONC) have heard from stakeholders that CMS's extensive documentation requirements for Evaluation and Management codes have resulted in unintended consequences. To meet these documentation requirements, providers have to create medical records that are a collection of predefined templates and boilerplate text for billing purposes, in many cases reflecting very little about the patients' actual medical care or story.

Responding to stakeholder concerns, several provisions in the proposed CY 2019 Physician Fee Schedule would help to free EHRs to be powerful tools that would actually support efficient care while giving physicians more time to spend with their patients, especially those with complex needs, rather than on paperwork. Specifically, this proposal would:

- Simplify, streamline and offer flexibility in documentation requirements for Evaluation and Management office visits — which make up about 20 percent of allowed charges under the Physician Fee Schedule and consume much of clinicians' time;
- Reduce unnecessary physician supervision of radiologist assistants for diagnostic tests; and
- Remove burdensome and overly complex functional status reporting requirements for outpatient therapy.

Advancing Virtual Care

"CMS is committed to modernizing the Medicare program by leveraging technologies, such as audio/video applications or patient-facing health portals, that will help beneficiaries access high-quality services in a convenient manner," said Administrator Verma.

Getting to the doctor can be a challenge for some beneficiaries, whether they live in rural or urban areas. Innovative technology that enables remote services can expand access to care and create more opportunities for patients to access personalized care management as well as connect with their physicians quickly.

Innovative technology that enables remote services can expand access to care and create more opportunities for patients to access personalized care management as well as connect with their physicians quickly.

Provisions in the proposed CY 2019 Physician Fee Schedule would support access to care using telecommunications technology by:

- Paying clinicians for virtual check-ins – brief, non-face-to-face appointments via communications technology;
- Paying clinicians for evaluation of patient-submitted photos; and
- Expanding Medicare-covered telehealth services to include prolonged preventive services

Lowering Drug Costs

President Trump is putting American patients first and lowering prescription drug costs, and CMS is committed to advancing this effort. CMS is proposing changes as part of the continued rollout of the Administration's blueprint to lower drug prices and reduce out-of-pocket costs.

The changes would affect payment under Medicare Part B. Part B covers medicines that patients receive in a doctor's office, such as infusions. CMS is proposing a change in the payment amount for new drugs under Part B, so that the payment amount would more closely match the actual cost of the drug. This change would be effective January 1, 2019, and would reduce the amount that seniors would have to pay out-of-pocket, especially for drugs with high launch prices. This is one of many steps that

CMS is taking to ensure that seniors have access to the drugs they need.

Proposed CY 2019 Quality Payment Program Key Changes

To implement the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), CMS established the Quality Payment Program (QPP), which consists of two participation pathways for doctors and other clinicians – the Merit-based Incentive Payment System (MIPS), which measures performance in four categories to determine an adjustment to Medicare payment, and Advanced Alternative Payment Models (Advanced APMs), in which clinicians may earn an incentive payment through sufficient participation in risk-based payment models.

The proposed changes to QPP aim to reduce clinician burden, focus on outcomes, and promote interoperability of electronic health records (EHRs), including by:

- Removing MIPS process-based quality measures that clinicians have said are low-value or low-priority, in order to focus on meaningful measures that have a greater impact on health outcomes; and
- Overhauling the MIPS "Promoting Interoperability" performance category to support greater EHR interoperability and patient access to their health information, as well as to align this performance category for clinicians with the proposed new Promoting Interoperability Program for hospitals.

Under the requirements of the Bipartisan Budget Act of 2018, CMS is continuing the gradual implementation of certain MIPS requirements to ease administrative burden on clinicians. The proposed changes to the Quality Payment Program reflect feedback and input from clinicians and stakeholders, and we will continue to offer free and customized support from CMS's technical assistance networks.

Medicare Advantage Qualifying Payment Arrangement Incentive (MAQI) Demonstration

Aligning with the agency's goals of improving quality of care and responding to the feedback we have received from clinicians, CMS also proposes waivers of MIPS requirements as part of testing a demonstration called the Medicare Advantage Qualifying Payment Arrangement Incentive (MAQI) demonstration. The MAQI demonstration would test waiving MIPS reporting requirements and payment adjustments for clinicians who participate sufficiently in Medicare Advantage (MA) arrangements that are similar to Advanced APMs.

Some Medicare Advantage plans are developing innovative arrangements that resemble Advanced APMs. However, without this demonstration, physicians are still subject to MIPS even if they participate extensively in Advanced APM-like arrangements under Medicare Advantage. The demonstration will look at whether waiving MIPS requirements would increase levels of participation in such MA payment arrangements and whether it would change how clinicians deliver care.

Price Transparency: Request for Information

Finally, as part of its commitment to price transparency, CMS is seeking comment through a Request for Information asking whether providers and suppliers can and should be required to inform patients about charge and payment information for healthcare services and out-of-pocket costs, what data elements would be most useful to promote price shopping, and what other changes are needed to empower healthcare consumers.

For a fact sheet on the CY 2019 Physician Fee Schedule proposed rule, please visit: www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2018-Fact-sheets-items/2018-07-12-2.html

To view the CY 2019 Physician Fee Schedule proposed rule, please visit: www.federalregister.gov/public-inspection

For a fact sheet on the CY 2019 Quality Payment Program proposed rule, please visit: www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/2019-QPP-proposed-rule-fact-sheet.pdf

To view the CY 2019 Quality Payment Program proposed rule, please visit: www.federalregister.gov/public-inspection/

For a fact sheet on the Medicare Advantage Qualifying Payment Arrangement Incentive (MAQI) Demonstration, please visit: www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2018-Fact-sheets-items/2018-07-12.html

Source: Centers for Medicare & Medicaid Services (CMS)

THE IMPACT OF "CHRONIC" BILL ON MEDICARE ADVANTAGE PLANS

On February 9, 2018, Congress reached a significant two-year budget agreement that will impact benefits offered through Medicare Advantage plans. The Bill, labeled CHRONIC (Creating High Quality Results and Outcomes Necessary to Improve Chronic Care) Act was passed in October of 2017. The Act includes a number of innovative strategies for both Medicare Advantage (MA) plans and Accountable Care Organizations (ACO). Following are just some examples of language in the Act that will make it easier and more cost effective for MA plans and ACOs to care for members.

MEDICARE ADVANTAGE PLANS

- Will now be allowed to include nonmedical services, such as home-delivered meals or rides to a doctor in their benefit packages.
- Have greater flexibility to cover non-medical benefits for identified high-need/high-risk members, such as bathroom grab bars and wheelchair ramps.
- Instead of a one-size-fits-all approach to care, Medicare Advantage would allow patients and providers to interact through tailored, targeted programs better suited to specific beneficiary groups.

The objective of the new law is to provide more flexibility to organizations to improve management of chronic disease, and improve quality outcomes ...

- Allows MA Plans to add benefits that go beyond pure healthcare to allow the conditions that help perpetuate chronic conditions to be mitigated and managed.
- The Act requires that a study be conducted to determine the type of supplemental benefits provided, the total number of enrollees receiving such benefits, the frequency the benefit is utilized and whether the supplemental benefit is covered by and additional premium

ACCOUNTABLE CARE ORGANIZATIONS (ACO)

- ACOs can choose to assign beneficiaries prospectively, rather than retrospectively.
- ACOs would also be free to utilize their resources to help beneficiaries with care at far more of their own discretion.
- Allows certain ACO models to provide beneficiary incentives for qualifying services

The objective of the new law is to provide more flexibility to organizations to improve management of chronic disease, streamline care coordination, and improve quality outcomes without adding to the budget deficit.

Desert Oasis Pharmacists Visit Sacramento to Advance HPN Interests

By Brian Hodgkins, Pharm.D.

With an intensifying use of pharmacist practitioners within the medical group families of Heritage Provider Network (HPN), Desert Oasis jumped into the 2017 - 2018 California State Legislative cycle by helping author some bills to address the healthcare access concerns of managed Medi-Cal patients.

DOHC worked with a statewide group of pharmacy leaders to draft six new bills to be considered by State legislators covering issues that included medication reconciliation, hypertension management, complex medication management and the role of advance practice pharmacists in managing complex chronic conditions. As one of a handful of Advance Practice Pharmacists within the state, Lindsey Valenzuela Pharm.D., BCACP, APh helped to draft SB1285, as well as collaborated in the creation of SB1322 and SB1264.

SB1285 was designed to allow Advance Practice Pharmacists, working under collaborative practice agreements (CPA's) with physicians, to provide comprehensive medication management services. Specifically, these were for plans regulated by the California Department of Managed Health Care or policies regulated by California Department of Insurance, as well as Medi-Cal managed care through either a DMHC regulated plan or a County Operated Health System. In all, roughly 23.4 million Californians would be affected. SB1264 was more specific to allow pharmacists to manage hypertension under CPA's for Medi-Cal covered patients.

As the only pharmacist available to make the trip to the State capitol to give testimony to Senator Ed Hernandez's Health Committee, I presented three bills and answered questions while defending the idea that pharmacists can solve a critical access need for patients with chronic health conditions such as diabetes, hypertension, COPD and more. After a 39 – 0 vote in the Senate, SB1264, along with another bill focusing on medication reconciliation, may make it to a joint vote in the Assembly and eventually to the Governor's desk.

We will keep you posted on the progress of this bill, but more importantly how HPN continues to promote ideas and solutions to improve healthcare in the communities it serves and for all Californians.

Pictured from left to right: Mary Kramer, Group Publisher, Chicago, Cleveland, Detroit & New York, Crain City/Regional Business; Timothy C. Peck, MD, Co-Founder and CEO, Call9; Matt Loper, CEO and Co-Founder, Wellth; Jorge R. Petit, MD, CEO, Coordinated Behavioral Care; Richard Merkin, MD, President and CEO, Heritage Provider Network; David Sandman, PhD, President and CEO, New York State Health Foundation and Mark Wagar, President, Heritage Medical Systems

Heritage Provider Network And Crain's New York Business, Custom Division, Announce Winners In The 3rd Annual Heritage Healthcare Innovation Awards For New York

On May 22, 2018, Heritage Provider Network (HPN) one of the nation's most experienced and effective physician-led, value-based care organizations and Crain's Custom Studio, a marketing story-telling division of Crain's New York Business, announced the winners in the 3rd Annual Heritage Healthcare Innovation Awards. The awards honored those innovators who have most improved the access to and quality of affordable healthcare in the communities they serve in the greater New York area.

Winners were announced in the following five categories at a luncheon ceremony at the New York Athletic Club in Manhattan on May 21, 2018.

Heritage Innovation in Healthcare Delivery Award: Timothy C. Peck, M.D., *Co-founder and CEO, Call9*

Recognizing an innovator in the development of new modes of diagnosis, treatment and care who actively improves access to services and improves the quality of healthcare overall.

With the founding of Call9, Dr. Peck has innovated healthcare delivery operations by embedding multi-disciplinary emergency telemedicine services at skilled nursing facilities, staffed with remote emergency physicians who work with on-site emergency technicians.

Heritage Innovator in Healthcare Award: Matt Loper, *CEO and Co-founder, Wellth*

Highlighting cutting edge applications of technology and up-and-comers in the healthcare industry. These breakthrough innovators are making significant contributions in the areas of technology, research, or new approaches to healthcare systems.

Wellth, founded by Loper, offers an incentive based behavioral change platform to improve adherence to medication and care plans.

Heritage Research Investigators in Translational Medicine Award: **Thomas Fuchs, Ph.D.,** *Co-founder and Chief Science Officer, Paige AI; Director, Computational Pathology, Warren Alpert Center for Digital and Computational Pathology, Memorial Sloan Kettering Cancer Center; Professor, Weill Cornell Graduate School of Medical Sciences*

Awarded to an individual or team based on the most significant quantitative results achieved by accelerating the transition of novel and innovative diagnostic tools and treatments to patients.

Paige AI, a Manhattan start-up, founded by Fuchs, seeks to revolutionize clinical diagnosis and treatment of cancer by applying artificial intelligence to pathology.

Heritage Healthcare Leadership Award: David Sandman, Ph.D., *President and CEO, New York State Health Foundation*

Recognizing a leader in the New York area that has demonstrated significant impact in their healthcare field. This forward-thinker has forever changed the way care systems work through new models, processes and pathways.

NSY Health Foundation, under Sandman's leadership, has played a transformational role in its efforts to improve the health of New Yorkers; providing grants to organizations with health care projects that are sustainable can be replicated and scaled up.

Heritage Healthcare Organizational Leadership Award: **Jorge R Petit, M.D.** *on behalf of Coordinated Behavioral Care*

Honoring an organization that has fundamentally changed how healthcare is delivered. This organization has created or championed new ways of thinking and doing, uniting diverse constituencies to work together.

Coordinated behavioral Care provides critical support for the mentally ill in our community who are dealing with chronic physical and behavioral health condition.

The healthcare awards competition garnered nominations across the spectrum of New York healthcare, from exciting early stage startups, to long established centers of New York Medical innovation. The complete list of 26 finalists can be found at crainsnewyork.com/heritage.

"The winners deserve our heartiest congratulations as they exemplify the top leadership and innovation ideas changing healthcare delivery for millions of New Yorkers," said Dr. Richard Merkin, President and CEO of HPN. "Their continued commitment presents opportunities to explore new ways to assure New Yorkers they are receiving cutting edge ideas while implementing cost saving measures as well."

"We are very proud to partner with Heritage Provider Network for the 3rd Annual Heritage Healthcare Innovation Awards. Their awards recognize health care innovators who have improved the lives of millions of New Yorkers," said Mary Kramer, Group Publisher for Crain's New York Business. "We are thrilled with the momentum of this program — the most nominations of all three years this year — and applaud their continued commitment to showcase leaders who are thinking big or exploring new and novel health care approaches, offerings or services. We congratulate the 2018 Heritage Healthcare Innovation award finalists and winners."

"The winners deserve our heartiest congratulations as they exemplify the top leadership and innovation ideas changing healthcare delivery for millions of New Yorkers." ~ *Dr. Richard Merkin*

"Hundreds of nominations. Twenty-six finalists. And now, five incredible winners. All examples of the New York healthcare community leaning forward, not accepting the way things have always been, and showing us ways to improve health, care, access, and cost for millions of New Yorkers," said Mark Wagar, President of Heritage Medical Systems.

with Heritage Provider Network's Dr. Richard Merkin on Healthcare Innovation

By Erica Teichert, Modern Healthcare, September 15, 2018

Managed-care organization, Heritage Provider Network, based in Marina del Rey, Calif., has focused on accountable care and value-based care since its inception in 1979. Now, its network of more than 3,700 primary-care physicians and 12,000 specialists serves more than 1 million patients in Arizona, California, Missouri, and New York. Dr. Richard Merkin has led the network from the beginning and continues to look for cutting-edge treatment and innovative solutions to improve care. Modern Healthcare News Editor, Erica Teichert recently talked with Merkin. The following is an edited transcript.

MH: ***What do you feel has helped Heritage be so successful in the ACO program?***

Merkin: What has helped Heritage, generally, is not embracing the status quo, but embracing change. Our charter has always been to do things that have never been done before. I think taking that approach, taking a less traveled path, has helped us become what we are today.

MH: ***Can you give me any examples of what you've done that you feel has never been done before?***

Merkin: When we first started, everybody was sort of doing the same thing. We looked at value-based healthcare as a blank slate. For example, in 1979 we started what is today a hospitalist program, with dedicated positions in the hospital and in the post-acute settings. I think it was 1996 when it became a specialty. But we invented that.

We were the first physician-owned organization in the country that managed the entire care of the patient, which is considered global risk today, for a fixed dollar amount.

We use machine learning; we use artificial intelligence. Part of our team includes professors of computer science, people who would normally not be part of a medical group. We have relationships with public-private partnerships with Harvard, MIT, Cal Tech. More recently, we started

the Institute for Transformative Technologies in Healthcare, which more formalized things we've done for many years.

MH: ***That's interesting that you've brought in people into your network that you wouldn't necessarily think of as healthcare providers.***

Merkin: Their goal is not to do what has previously been done. They want to do something that will have an effect on healthcare at a very broad base. Now, mind you, what I normally see is we get lots of people from Silicon Valley who come to us and say, "I have this great solution. Do you have a problem that it fits?" And we didn't think that worked. So, what we did is we've taken these very talented, smart and educated computer scientists and brought them into different departments and had them educated on the nuances and the issues that practicing physicians have every day, and the different regulations, etc.

MH: ***How has the healthcare industry changed during the last several decades and where do you see it going forward?***

Merkin: Change is accelerating exponentially. It used to take a longer period of time between something being invented and it being implemented. Today, the time is truncated.

MH: ***The CMS recently announced that it's going to retire zero- and low-risk ACO tracks. How do you think that's going to affect the industry's move to value-based care?***

Merkin: Physicians have to take on more responsibility. I think we're going too slow. Physicians have to work together; they have to collaborate. I think culture unlocks value. I don't think we would have been able to achieve what we have unless our teams were unified, worked together as a team, and worked hard to serve our members. I think a lot of these programs evolve. Our goal was to go from horse and buggy to electric cars, but other organizations were just trying to make a faster horse.

> "I think culture unlocks value. I don't think we would have been able to achieve what we have unless our teams were unified, worked together as a team, and worked hard to serve our members."
> ~ Dr. Richard Merkin

MH: ***You've mentioned how innovations are developing faster than ever now. And then you juxtapose that versus the ACO program and the move to value-based care. From your perspective, how slow it seems to be going.***

Merkin: Our organization went from fee-for-service to global risk immediately. We built systems for global risk. So, we were responsible for the totality of care. At least initially, we were also responsible for pharmaceutical cost. Over time, the health plans found that there were many groups that couldn't manage that. Part of it was lack of data. Generally, medical groups are not held accountable for pharmaceutical costs. But now we are doing this incrementally, and I'm uncertain if that's the best way to do it.

MH: ***Was changing from fee-for-service to global risk a challenge for Heritage?***

Merkin: It was exciting. Necessity is the mother of invention. When we started we were challenged by Blue Cross and Blue Shield, who said, "This is impossible." And yet, that was what caused us to find it exciting. The crazy ideas of one day, like putting a doctor in the hospital full time, was a breakthrough the next. Having a team of doctors evaluate a patient for best outcomes was a crazy idea. Doctors, historically, didn't work in teams. Today, that's pretty routine. We found it stimulating.

I would suggest that all of the people who were the creators, none of them had any experience. So, they did not know what could not be done. What we tried to choose were people of talent, grit and resilience. In fact, the first person that I hired, I only asked him one question. He was a chemistry professor. I asked him, "If you hear no, no, no, no, no, no all day long. By the

"We believe value is giving people the access to care they need to prevent unnecessary and avoidable health events."
~ Dr. Richard Merkin

end of the week, do you get depressed?" He said, "No, I'm pretty resilient." The reason that I asked him that is he was doing something that's different from what other people were doing. People don't like change. So, you're going to hear no a lot. But you only have to hear one yes. I believe very strongly that one person can change the world.

More recently, people with experience applied for positions and they say, "Oh, you can't do that." We point out that we've been doing it for 20, 30 or 40 years. But they don't believe something can be done because they "already have experience" in other organizations.

The other thing that I see frequently is people who say, "Well, I've had 20 years of experience." I find out that frequently, they've had one year of experience 20 times. They learn a job in the first few months or first six months, and they had been doing the exact same thing their entire career without evolving, changing. The environment is constantly changing, and you need creativity, curiosity. Why can't it be done differently? Why can't something be done just because you're the first on the block to do it?

MH: ***More insurers, including Oscar Health recently, are diving into the Medicare Advantage space or harnessing narrow networks. How could that benefit providers and patients?***

Merkin: They are certainly looking at healthcare differently than it has been looked at historically. It will be interesting to see how they approach the senior market, which is a different market than commercial. I'm certain that their experience with what they've done now, they will be able to build on. And take into consideration the differences, and hopefully they will be successful and help make the MA program even more successful than it has been.

MH: ***How do you define value when it comes to healthcare?***

Merkin: We believe value is giving people the access to care they need to prevent unnecessary and avoidable health events. To do so in an environment that is characterized by very high quality, and importantly, excellent patient experience. Just by definition, that would lower the cost and make healthcare more affordable.

MH: ***Do you think the incentives are properly aligned for providers to really add value to care?***

Merkin: Unfortunately, not all incentives are properly aligned. But I see that there has been great progress and a much clearer understanding across the country of the direction in which we need to head. It's a continuing mission, but it's getting better.

Source: Modern Healthcare, September 15, 2018

Heritage Provider Network Affiliated Medical Groups

THE LARGEST INTEGRATED PHYSICIAN-LED MEDICAL GROUP NATIONALLY

For 40 years, HPN has provided quality, cost-effective healthcare to the communities we serve. Today, HPN and its affiliates manage the healthcare of more than one million individuals. Our network has thousands of primary care physicians and specialists and hundreds of hospitals.

ADOC Medical Group
www.adoc.us
Phone: 800-747-2362
600 City Parkway West, Suite 400,
Orange, CA 92868
Counties Served: Central and North Orange County

Arizona Priority Care (AZPC)
www.azprioritycare.com
Phone: 480-499-8700
585 N. Juniper Dr., Suite 200
Chandler, AZ 85226
Counties Served: Maricopa County and areas of Pinal County (Casa Grande Area)

Bakersfield Family Medical Center
www.bfmc.com
Phone: 661-327-4411
4580 California Ave.
Bakersfield, CA 93309
Counties Served: all of Kern County

Coastal Communities Physician Network
www.ccpnhpn.com
Phone: 800-604-8752
1305 Marsh St.
San Luis Obispo, CA 93401
Counties Served: Arroyo Grand, Atascadero, Los Osos, Morro Bay, Paso Robles, Pismo Beach, San Luis Obispo, Templeton and Tulare

Desert Oasis Healthcare
www.mydohc.com
Phone: 760-320-5134
275 N. El Cielo Rd.
Palm Springs, CA 92262
Counties Served: Imperial, Riverside, and San Bernardino

HealthCare Partners, IPA
www.hcpipa.com
Phone: 516-746 -2200
501 Franklin Ave.
Garden City, NY 11530
Counties Served: Manhattan, Queens, Bronx, Brooklyn, Nassau, Suffolk, Westchester

Heritage New York Medical, P.C.
Phone: 516-531-2001
1225 Franklin Ave., Suite 100
Garden City, NY 11530
Counties Served: Manhattan, Queens, Bronx, Brooklyn, Nassau, Suffolk, Westchester

Heritage Victor Valley Medical Group
www.hvvmg.com
Phone: 760-245-4747
12370 Hesperia Rd., Suite 6
Victorville, CA 92395
Counties Served: Los Angeles and San Bernardino

High Desert Medical Group
www.hdmg.net
Phone: 661-945-5984
43839 N. 15th Street West
Lancaster, CA 93534
Counties Served: Los Angeles and Kern

Lakeside Community Healthcare
www.lakesidemed.com
Phone: 818-637-2000
8510 Balboa Blvd., Suite 150
Northridge, CA 91325
Counties Served: Los Angeles, Ventura, Riverside, and San Bernardino

Regal Medical Group
www.regalmed.com
Phone: 866-654-3471
8510 Balboa Blvd., Suite 150
Northridge, CA 91325
Counties Served: Los Angeles, Orange, Riverside, San Bernardino, San Diego, and Ventura

Sierra Medical Group
www.sierramedicalgroup.com
Phone: 661-945-9411
44469 N. 10th Street West
Lancaster, CA 93534
Counties Served: Kern, Los Angeles, and San Bernardino

*touch*points

Heritage Provider Network
8510 Balboa Blvd., Suite 150
Northridge, CA 91325-5810

Our Awards

Recognition of Commitment and Excellence

The recognition we have received demonstrates our practices in excellence. We're proud to be awarded for our commitment to our members and our community.

Wellness Excellence Award in Health Education – Southern California Foundation for Health Care

Top Ten Physician Medical Networks in California by the California Association of Physician Groups

NCQA Certification for Credentialing

Elite Status of Excellence for the Standards of Medical Care by the California Association of Physician Groups

Recognized by the Integrated Healthcare Association (IHA) for our diabetic registries