The keys to building a successful approach to a population health management organization

Joe Damore, FACHE
Vice President
Premier Inc.

October 8, 2015
Agenda

• Introduction/Purpose
• Environmental Update
  – Policy Developments
  – Market Response
• New Care Models
• New Payment Models
  – Medicare Shared Savings Program
  – Bundled Payment
  – Commercial Models
• Keys to Successful Implementation
• Optimizing Financial Performance
• Summary
• Questions and Next Steps
Speaker Biography

Joseph F. Damore, FACHE, Vice President of Premier’s Partnership for Care Transformation (PACT) Collaborative, is responsible for assisting not for profit hospitals and health systems in developing integrated health systems and in implementing Accountable Care Organizations. He provides consultative assistance to both Premier PACT Readiness and Implementation Collaborative members. Mr. Damore has provided counsel and assistance to health care executives, physician leaders, and Board members in developing integrated health systems in more than a dozen states.

Prior to joining Premier, Mr. Damore served as CEO of Mission Health System from 2004 to early 2010 and the Sparrow Health System from 1990 to 2004. Prior to his tenure as a CEO he served as an executive with Mercy Health Services (Trinity Health), Western Reserve Health System, and Greenville (S.C.) Hospital System. For the past year he was President of JFD Consulting, LLC, a firm focused on helping hospitals and health systems prepare for health care reform and in the development of integrated health systems and Accountable Care Organizations.
Introduction
“The past 50 years have been marked by advances in the science of medicine.

The next 50 will be marked by improvements in the organization and teamwork of how health care is delivered.”

– Charles H. Mayo
Environmental Update
The transformation to population health management

Population Health Management “The coordination of care delivery across a population to improve clinical and financial outcomes, through disease management, case management and demand management”

Increasing Market Pressure

Federal

- Current Medicare enrollment is projected to increase from approximately 54M today, to 85M by 2035
- Dramatic projected growth of all major chronic diseases
- FFS payment cuts

State

Employee / Commercial

Federal Debt Held by the Public, 1912 to 2037

STATE SPENDING PROPOSALS FOR 2012

Employee / Commercial

Cumulative Increases in Health Insurance Premiums, Workers’ Contributions to Premiums, Inflation, and Workers’ Earnings, 1999-2011
What drives our debt: Entitlement spending as share of economy

SOURCE: CBO
Healthcare spending; aging population driving deficit and debt
10k new Medicare beneficiaries a day

Projected Medicare enrollment (in millions)

Source: 2012 Annual Report of the Boards of Trustees for the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds
### HHS goals: Aggressive shift to value-based payments

**Volume to Value**

<table>
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<tr>
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<th>2016</th>
<th>2018</th>
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<tbody>
<tr>
<td>Alternative payment models</td>
<td>30% of all Medicare payments</td>
<td>50% of all Medicare payments</td>
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<tr>
<td>Value-based payments</td>
<td>85% of all Medicare payments</td>
<td>90% of all Medicare payments</td>
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**Better Care. Smarter Spending. Healthier People.**

**Learning**
- HHS, private payers, large employers, providers, consumers, and state & federal partners
- Develop common approaches to core issues
- Collaborate to generate evidence, share approaches & remove barriers
- Create implementation guides for payers and purchasers

**Action Network**
- Expand patients’ access to cost and quality information to enable smarter decision-making
- Improve HIT interoperability to inform care across the continuum

**Cost & quality Transparency**
Environmental Update: Policy Updates
Governmental Policy/Payment Developments

• National Policy Developments
  • **HHS Announcement** (1/26/15) to increase speed of the transformation to value based payment/CMS Learning center
  • New **Oncology** Care Model Program
  • **Next Generation** ACO Model
  • **MACRA / SGR FIX** - physician incentives to value based payment programs passed the senate on April 14, 2015
  • **New MSSP rules** (400+MSSPs)
  • **CCJR** mandatory bundled payment program in 75 MSAs

• State Reform Developments
  • **SIM state planning grants** (AZ, KY, VA, MD, WI, etc.)
  • Expansion of **private Medicaid model** (IA, PA, AR, UT, IN)
  • **Episodes of Care Medicaid model** (AR, TN, OH)
  • **ACO Model** (OR, CO, AL)
  • **DSRIP Model** (TX, CA, NJ, NY)
What’s next?

- **MACRA** - physician incentives to value based payment programs
- **Continued expansion of alternative Medicare payment models**
  - Oncology bundled payment program
  - Revised MSSP rules
  - Next Generation ACO Model
  - Comprehensive Care for Joint Replacement Model (CCJR)
- **Medicaid reform with increased utilization of insurance exchanges and expansion**
- **Acceleration of commercial payor, value based payment models**
- **Increase number of provider sponsored health plans**
- **Direct contracting with employers**
- **Primary care global payment/virtual care**
- **Care redesign based on episodes of care**
Medicare Access and CHIP Reauthorization Act of 2015

Replaces the 1997 SGR formula, which capped Medicare physician per beneficiary spending growth at GDP growth rate

- Overwhelming bipartisan support.
- Provides new tools in implementing the payment reforms.
- Applies to MD, DO, PA, NP, Clinical nurse specialist, nurse anesthetist.
- 2021 includes therapists, psychologists, social workers, audiologists, and dieticians.
- Creates clear timetable and benchmarks.

On 3/26, the House passed H.R. 2 by 392-37 vote.

On 4/14, the Senate passed the House bill by a vote of 92-8, and the President signed the bill.
Maryland Developments

- Revised Federal Waiver/New All-Payor System
- Regional integrated healthcare system growth/expansion
- Medicaid reform/expansion
- Medicare Shared Savings Program growth
- CareFirst expansion into MSSP/CMMI demonstration
- State Insurance Exchange implementation
Environmental Update: Market Response
The journey to population health management

**High Performing Hospitals**
- Cost management
- Waste elimination
- Best outcomes in quality, safety
- Satisfied patients
- Physician alignment
- Growth strategies

**High Value Episodes**
- DRG and episode targeting
- Care models
- Gainsharing
- Data analytics
- Cost management
- Physician integration

**Population Management**
- Population analytics
- Care management
- Financial modeling and management
- Legal
- Physician integration and leadership
- Covered lives

MOVEMENT TO INTEGRATED CARE, NEW PAYMENT MODELS & RISK

- Value-based purchasing: HACs, quality, efficiency
- Bundled payment
- Global payments

- Reimbursement cuts
- Medical home
- Shared savings
- Medical home
ACO development continues to accelerate

- Nearly 700 Commercial and Medicare ACOs now operating
- 7.8 M Medicare lives are covered
- For first time in decades the Medicare per capita growth was below GDP growth

CMS Bundled Payment initiative:
- Model 1: 12 Participants
- Model 2: 2,180 Participants
- Model 3: 4,727 Participants
- Model 4: 17 Participants

- 42 state Medicaid/Chip programs planning/implementing PCMH
- 27 states making medical home payments
- 18 involved in multi-payer pilots
Trend: Fee for service → Population management

Total Medicare beneficiaries

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Medicare beneficiaries</th>
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<tbody>
<tr>
<td>2010</td>
<td>46,589,000</td>
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<tr>
<td>2011</td>
<td>47,672,000</td>
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<tr>
<td>2012</td>
<td>49,435,000</td>
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<tr>
<td>2013</td>
<td>52,000,000</td>
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<tr>
<td>2014</td>
<td>54,000,000</td>
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<tr>
<td>2015 (est.)</td>
<td>55,000,000</td>
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ACOs continue to show promise

- **MSSP performance year 2014 results for ACOs with 2012, 2013 and 2014 start dates**
  - Qualifying MSSP ACOs earned $341 million in shared savings, having kept spending $806 million below their targets.
  - An additional 89 ACOs kept spending below their targets, but did not produce enough savings to meet the minimum threshold to earn a bonus payment.
  - MSSP ACOs saved the Medicare Trust Funds a total of $465 million in 2014, an increase over the $383 million saved in 2013.
  - No ACOs in the Track 2 model, which is the two-sided risk model, owed CMS shared losses.
  - ACOs that reported in both 2013 and 2014 improved their performance on 27 of 33 quality measures.
  - Participants surpassed other Medicare fee-for-service providers' performance on 18 of the 22 Group Practice Reporting Option (GPRO) Web Interface measures.

- **Pioneer ACO performance year 3 results**
  - Pioneer ACOs achieved total model savings of over $120 million--up from $96 million in Performance Year 2. Eleven ACOs qualified for shared savings of $82 million.
  - While five Pioneer ACOs generated losses, only three exceeded the minimum loss rate and owed the Medicare program shared losses of $9 million.
  - Pioneer ACOs raised their mean quality score from 85.2 percent in Year 2 to 87.2 percent in Year 3.
  - ACOs improved their performance in 28 of the 33 quality measures and showed average improvements of 3.6 percent across all quality measures compared to the second year of the program.

Source: CMS press release; CMS fact sheet
<table>
<thead>
<tr>
<th>ACO and Entry Date</th>
<th>Service Area</th>
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<tr>
<td>MSSP ACOs – July 1, 2012</td>
<td>St. Mary’s County, Southern Maryland, Central Maryland, Greater Baltimore Maryland, Maryland, Pennsylvania, West Virginia, Maryland, DC, and 7 other states</td>
</tr>
<tr>
<td>Accountable Care Coalition of Maryland, LLC. Crystal Run Greater Baltimore Health Alliance Physicians, LLC Maryland Accountable Care Organization Of Eastern Shore LLC Maryland Accountable Care Organization Of Western MD LLC Meridian Holdings, Inc.</td>
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<tr>
<td>AAMC Collaborative Care Network Lower Shore ACO, LLC Maryland Collaborative Care, LLC Northern Maryland Collaborative Care, LLC Southern Maryland Collaborative Care, LLC</td>
<td>St. Mary’s County, Southern Maryland, Central Maryland, Greater Baltimore Maryland, Maryland, Pennsylvania, West Virginia, Maryland, DC, and 7 other states</td>
</tr>
<tr>
<td>Accountable Care Coalition of Maryland Primary Care, LLC Johns Hopkins Medicine Alliance for Patients, LLC Mid-Atlantic Primary Care ACO Privia Quality Network, LLC THP-Meritus ACO, LLC UR Care, LLC</td>
<td>Maryland, DC Maryland, DC Maryland, DC, Virginia Maryland, DC, Virginia Maryland, Pennsylvania, West Virginia Maryland, DC</td>
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</tbody>
</table>
What’s next?

- Implementation of the Maryland’s New All-Payor System
- Shifting even greater economic risk to delivery systems
- Continued growth in the Medicare Shared Savings arrangements
- State Medicaid reform integrating accountable care principles
- Value Based Payment arrangements moving to outcomes based
- Impact of state insurance exchanges (such as narrow networks)
- Development of private exchanges
- Movement from defined benefits to defined contribution health benefits
- Virtual office visits and “hospital in the home” model will expand and grow
New Care Models
The bridge from FFS to population health management

Core Components:
- People Centered Foundation
- Health (Medical) Home
- High Value Network
- Population Health informatics and technology
- Governance and Leadership
- Payor Partnerships

What are the underpinning building blocks?

Foundational Philosophy: Triple Aim™

Measurement
Transforming of Healthcare Delivery

- Patient Centered/Engaged
- Leadership/Cultural Transformation
- Primary Care Based/Patient Centered Medical Home
- Physician Led Clinical Integration
- Care Management Program
  - High Risk Populations
  - Chronic Disease Management
  - Transition of Care/Post-acute Care
- Integrated Delivery Systems
- Evidence Based Care Models
- Electronic Medical Record/Data Analytics
- Triple Aim Metrics
  - Health of the Population
  - Cost Per Capita
  - Patient Quality/Satisfaction/Engagement
Target Populations

- **2-3% of Population**
  - Complex Individual Case Management (40% of cost)
- **5-7% of Population**
  - Complex Disease Management – Embedded/Primary Care
- **20-25% of Population**
  - Disease Management – Virtual/Telephonic
- **100% of Population**
  - Wellness/Prevention

2-3% of Population

5-7% of Population

20-25% of Population

100% of Population
Clinically Integrated Network

- Independent Physicians
- Care Management Fees
- Transformational Funding
- Shared Savings
- Joint Negotiating
- ONE Network That can Demonstrate Value and Effectively Manage a Population

**Government**

**Employers**

**Population**

**System**

**Commercial**

**Clinically Integrated Network**

- Employed Medical Group
- Employee Health Plan
- Medical Center
- Ambulatory Facilities

**Health System**

- PCMH
- Care Managers
- IT Services
- Claims Analytics

**Value-Based Contract**

**Legal Relationship**

**Participation Agreement**
Patient Centered Medical Home

PCMH Expected Attributes:
- NCQA /other certification
- Adoption of standard IT system
- Use of care coordinators/managers
- Focus on team-based approach to care

Health System Support
- Provide access/support of IT adoption within PCP office
- Educate and provide training to PCP’s regarding PCMH adoption
- Assist with care redesign
- Jointly hire and train care coordinators/ managers
- Collaborate across practices to develop performance based metrics focused on quality, safety, care coordination and costs
Population-Based Care Management Framework

Increasing Health Risk

1. Well & Low Risk Members (Prevention)

2. Low Risk Members (Prevention and Disease Management)

3. Moderate Risk Members (Disease Management)

4. High Risk, Chronic, Multiple Disease States (Episodic Case Management - Inpatient Clinical Guidelines)

5. Complex Catastrophic Care (Inpatient - LTC) End of Life

Decreasing Health Risk

Prevention

Case Management

Disease Management

Source: Paul H. Keckley, Executive Director, Deloitte Center for Health Solutions, Washington DC PhD, 2007 National Predictive Modeling Summit: The Landscape for Predictive Models
Integrating care redesign and new payment models

**Care Redesign**
- Patient Centered Medical Home
- Clinical Integration
- Care Management
- Post-Acute Care
- Electronic Health Record
- Data analytics

**New Payment Arrangements**
- Care Transformation Costs
- Care Management Payment
- Shared Savings
- Episodes of Care Payment
- Global Payment

Care redesign must not outpace changes in payment

Population Health Transformation
New Payment Models
Population health market segments

- Employee Health Plan
- Self-funded Employers
- Private Health Plans
- Medicaid Program
- Medicare Program
- Uninsured
- Retail Health Insurance
Major Payor Developments

- Rapid movement toward consumer driven health plans and new payment arrangements
- Components of new payment models
  - Transformational funding
  - Care management
  - Shared Savings
- Early adopters include the following
  - Regional Blue Cross plans (MN, MA, IL, HA, etc.)
  - Commercial Health Plans (Aetna, Cigna, Humana, etc.)
- Partnering with MSSP ACOs
  - Universal American (34 MSSPs)
  - Walgreen’s (3)
- Building delivery systems
  - Highmark purchases seven hospitals/physician practices
  - Cigna – Primary Care Network (PCMH)-Phoenix
  - United HealthCare-Monarch physicians group (2300 physicians) and Optum
  - Aetna purchases Active Health
  - Da Vita acquires Healthcare Partners
- Growth in Provider Sponsored Health Plans
- Medicaid Managed Care/ACOs
- New Maryland Waiver All-Payor Program (Global Revenue Program)
New Payment Models: Medicare Shared Savings Program
Medicare Shared Savings Program
Key Provisions

- Beneficiaries will be assigned to an ACO based on the plurality of the primary care services received from primary care physicians and non-physician practitioners within an ACO.
  - If a beneficiary has not had a primary care service furnished by a PCP, assignment is based on a plurality of primary care services from certain specialist physicians within the ACO.
- 33 quality measures in four domains
  - Patient Experience
  - Care coordination and patient safety
  - Preventative health
  - Caring for at-risk populations
- Medicare Parts A, B and D data shared up to monthly.
- Beneficiaries can opt-out of data-sharing, but may need to seek care elsewhere if want to opt-out of the program entirely.

- Three payment tracks
  - Track 1 is upside risk only (50% savings shared)
  - Track 2 is bonus/penalty all 3 years. (60% savings / losses shared). Allows for a choice of symmetrical MSR/MLR
  - Track 3 is bonus/penalty all 3 years (75% savings/losses shared). Also includes prospective attribution, and choice of symmetrical MSR/MLR
- First dollar share on all savings after reaching the MSR
- ACOs are considered clinically integrated for antitrust.
- Five anti-trust and stark waivers offered to all Tracks
  - No mandatory, upfront anti-trust review
- FQHCs and rural health clinics may now lead ACOs
The shared savings model

New Payment Models: Bundled Payments
Bundled Payment Growing Across the Country

• Over 6,000 in CMS’ BPCI

National
• Recent HHS announcement-pushing bundled payment
• CMS announces Oncology Bundle

Private Market
• Commercial payors adopting BP arrangements
• Employers are entering BP arrangements directly with providers

State
• Arkansas, Tennessee, Ohio Medicaid Bundles
• States requesting Medicaid waivers
Two categories of bundled payments

1. Prospective
   - Up front, lump-sum bundled payment
   - Episode initiator (e.g. hospital) is administrator of claims
   - Agreed upon payment amount

2. Retrospective
   - Traditional fee-for-service payments from payer to all providers
   - Claims reconciled against target price after episode ends
   - Agreed upon target amount
Bundled Payments Continue to Gain Momentum

- Bundled Payment for Care Improvement Initiative (BPCI)
  - Entities first went live in October 2013
- Oncology Care Model (OCM)
  - Announced February 2015
  - Anticipated start date in Spring 2016
- Comprehensive Care for Joint Replacement Model (CCJR)
  - Proposed rule published on July 9, 2015
  - Proposed start date of January 1, 2016
- Commercial Outlook
  - Commercial payers following the lead of CMS
New Payment Models: Commercial Models
Consensus that the shift to population health based contracting is underway

Commercial payor value-based contracting strategies are still evolving

Several payors are integrating with primary care physicians (Humana, UHC/Optum, Highmark BC, etc.)

Data analytics and the IT infrastructure are critical in the shift to value-based contracting: Current capabilities in this area fall short and require further development by payors and providers

Inconsistencies in quality measurement approaches and metrics must be addressed: Variations among quality measurement programs and targets across payors is a significant challenge

Provider sponsored health plans are on the rise

Payors are beginning to “pick partners”, reducing number of provider partners per geographic area (especially for exchange products)
Commercial payors are aggressively transitioning to value based payment: Each payor’s strategic outlook is similar to the HHS’ goal to shift aggressively to value based contracts over the next five years.

- **Our goal within the next 5 year is for 70% of our network to be under value based payment contracts**

- **The majority of our revenue will come from value based contracts in <5 years**

- **Aetna’s outlook is to have 75% of our contracts under value based payment models by 2020.**

- **75% of our business in Medicare. Over the past 7 years Medicare FFS has grown by 13.5% and MA has grown by 60%**
Provider Sponsored Health Plans

Distribution of provider-led health plans in each state, number of plans offered

PHSP Landscape
- 107 health systems
- 18 million beneficiaries
- 8% of total lives
- Approximately 13% of health systems offer health plans

11% of employers are engaging in some form of direct contracting with employers, while another 28% expect to do so within the next 3-5 years (Aon Hewitt, 2014 p. 33)
Keys to Successful Implementation
1. Identify/communicate/engage beneficiaries
2. Select and implement data analytics platform
3. Establish a public and physician communications plan and office
4. Identify your highest risk population (2-3% of patients that are currently or are predicted to be the highest utilizers)
5. Establish a process to capture and report 33 measures (GPRO)
6. Develop a plan to grow market share by using data analytics to identify leakage and develop action plan
7. Establish robust team based patient centered medical homes (PCMH) across the participating MSSP provider network
8. Establish and implement a care management plan for high risk patients
9. Define and finalize a shared savings distribution methodology
10. Assess post-acute care processes and local market providers
Optimizing Financial Performance
# Optimizing Financial Performance During Transition to Population Health

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<tr>
<th>Segment</th>
<th>Strategies</th>
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<tr>
<td><strong>Market Share Growth</strong></td>
<td>- Claims analytics to enhance market share.</td>
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<tr>
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<td>- Wallet Share of per capita expenditures</td>
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<td>- Consolidation of IP services and redeployment of space for new services</td>
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<td></td>
<td>- Regional network/health plan development</td>
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<td>- Health Exchange volume growth</td>
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<tr>
<td><strong>Expense Reduction</strong></td>
<td>- Resize IP capacity to improve efficiency.</td>
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<td>- Utilize Population Health management techniques to reduce uncompensated</td>
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<td>care and Employee Health Plan costs</td>
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<tr>
<td></td>
<td>- Consolidate overhead across IDNs/Mergers, Joint Operating Agreements,</td>
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<td></td>
<td>Leased Services, etc.</td>
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<td></td>
<td>- 360 degree credentialing of employed physicians</td>
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<tr>
<td><strong>Payor Contract Enhancements</strong></td>
<td>- New Medicare billing codes for wellness and chronic disease management</td>
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<td></td>
<td>- Modified payment models with commercial payors, Medicare, and Medicaid</td>
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<td></td>
<td>where possible</td>
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<td></td>
<td>- Risk score (HCC) management</td>
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<tr>
<td><strong>Non-Acute/Non-Core Revenue Growth</strong></td>
<td>- New services/programs (e.g. wellness and chronic disease care management, retail Rx, urgent care, primary care evening and weekend hours, home care, business medicine, telemedicine)</td>
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<td>- TPA services and IDN sponsored insurance products</td>
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<td>- Post-acute care management program</td>
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Summary
“When we are no longer able to change a situation-we are challenged to change ourselves.”

Viktor E. Frankl
author, “Man’s Search for Meaning”
Questions and Next Steps
THANK YOU

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