Preconference I:
Coordinated Care 101: A Primer

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What You Can Expect from Today’s Session

- What does coordinated care mean, anyway?
- The range of risk arrangements and the approaches required to succeed
- What others have learned in their journey within population health management
- Take-away tools, approaches, and strategies to succeed within population health management
- An interactive session – sharing questions, answers, and observations
What’s On the Agenda

<table>
<thead>
<tr>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overview – Why Risk, Why Now?</td>
</tr>
<tr>
<td>Follow the Money: Population Risk Models</td>
</tr>
<tr>
<td>Care Model Execution and Clinical Cultural Transformation</td>
</tr>
<tr>
<td>Break</td>
</tr>
<tr>
<td>Aligning Incentives</td>
</tr>
<tr>
<td>Other Considerations for Success</td>
</tr>
<tr>
<td>General Q&amp;A</td>
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</tbody>
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Absorbing It All Is A Little Like ....
Why Risk, Why Now?
What Do These People Have in Common?
A Few Facts About the Market

- 31 percent of Medicare enrollees are in Medicare Advantage (“MA”) Plans; total enrollment grew by 7 percent between 2014-2015
  - 54 percent of new MA plans in the last 4 years were sponsored by a provider organization
- There are 744 ACOs nationwide; 423 Medicare ACOs
  - 23.5 million covered ACO lives (7.8 million Medicare)
  - 132 different payers have entered into at least one ACO contract (up from 51 in 2012)
- HHS wants 50 percent of fee-for-service (“FFS”) plans in Alternative Payment Models by 2018

Sources: Kaiser Family Foundation, Avalere Health LLC, Leavitt Partners
What Does the Marketplace Want?

- Cost control
- Providers incentivized to manage quality and cost
- Care coordination across the continuum
- Patient-focus: right care, right time, right place

Triple Aim™/Pop Health
What is the Market Getting?

- High deductible/co-pays to manage patient demands
- Exchange products require full coverage at low cost
- Discounted fee-for-service payments

Reduced Cost PPOs
A Combination of Factors Create Opportunity…and Risk

Opportunity for Global Capitation?
## Haven’t We Done This Before?

<table>
<thead>
<tr>
<th></th>
<th>1990’s Era Insurance Driven</th>
<th>ACA-Era Provider Driven</th>
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</thead>
<tbody>
<tr>
<td><strong>Economics</strong></td>
<td>Discounts</td>
<td>Contracts at Current Price</td>
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<td>Withholds</td>
<td>Incentives</td>
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<td><strong>Management</strong></td>
<td>Lower Utilization</td>
<td>Appropriate Utilization</td>
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<td>Prevention</td>
<td>Management of Chronic Disease</td>
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<td>Patients Enroll and then Gatekeeper</td>
<td>Attribution/Relationships and then Coordination</td>
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<td><strong>Market</strong></td>
<td>Booming Economy</td>
<td>Recession</td>
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<td>Limited Informatics</td>
<td>Robust Informatics</td>
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“Risk” Models Come in Many Flavors

“Riskometer”

High

Low

Fee-for-Service
- Pay-for-Performance + Cost Management Incentive
- Pay-for-Performance
- Pay-for-Reporting
- Discounted Fee Schedule
- Percent of Charges
- Full Charges

Episode of Care
- Prospective Payment
- Bundled Payment 90 Days
- Bundled Payment 30/60 Days
- Retrospective Payment
- “Shared Savings” Per Episode (e.g., Oncology)
- Case Rate or DRG

Population Risk
- Full/Global Risk
- ACO or Shared Savings – Upside and Downside
- Professional OR Institutional Capitation
- ACO or Shared Savings– Upside Only
- Case Management Fee Plus Incentive (e.g., PCMH)

Critical Success Factors
- Cost Per Unit
- Market Price Sensitivity
- Volume
- Billing/Coding
- Patient Satisfaction

- Per Episode and Per Unit Cost
- Case Volume
- Care Coordination Across Continuum
- Physician Engagement
- Adherence to Protocols
- Quality/Experience Outcomes

- Covered Population Size
- Patient Attribution
- Total Cost of Care and Risk Adjusters
- Care Redesign Across Continuum
- Patient and Physician Engagement
- Quality/Experience Outcomes
- Multi-year Agreements + Reserves
What Strategy Makes Sense for You?

- Creating the “glue” for clinical integration – sharing risk without merging
  - Separate healthcare systems
  - Separate medical groups
  - Other joint ventures
- Plan-to-plan private label products
  - Self-insured employers (including provider employees!)
  - Evolution of ACOs into capitation
- Provider-owned health plan
  - Commercial products
  - Medicare Advantage, Medicaid managed care
  - Regional product for Exchange
Follow the Money: Population Risk Models
Managing Healthcare Costs

THE CAMDEN GROUP | 10/05/2015
Population Risk

Today's Focus is on the "Higher Risk" Models

- Care Management Fee Plus Incentive (e.g., PCMH)
- ACO or Shared Savings (Upside Only)
- Professional or Institutional Capitation (Partial Cap)
- ACO or Shared Savings (Upside and Downside)
- Full/Global Risk
Types of Organizations Taking Risk

Source: CMS, 2015. Note: ACOs could select more than one option.
1 Not reflective of all risk bearing organizations, representative of MSSP participants only
Types of Organizations Taking Risk

Clinically Integrated Networks of Hospitals and Physicians

Partnerships Drive Success and Sustainability

Diagram showing the relationships between CI Network, Regional CIN, and Physicians within Region CIN/ACO.
## The Evolution of Clinical Integration and Management of Risk

<table>
<thead>
<tr>
<th>Phase 1</th>
<th>Develop the Structure</th>
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<tbody>
<tr>
<td>Build the organizational infrastructure</td>
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<tr>
<td>Establish quality programs, incentive models, and outcome tracking</td>
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<tr>
<td>Develop care management infrastructure</td>
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<td>Enter into limited risk-based contracts</td>
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<tr>
<th>Phase 2</th>
<th>Establish Partnerships</th>
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<td>Leverage infrastructure with providers in new markets</td>
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<tr>
<td>Develop products</td>
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<td>Partner with payer(s) (carrier as the middle-man)</td>
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<td>Larger provider network</td>
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<td>Access to membership</td>
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<td>Direct to employer contracts</td>
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<thead>
<tr>
<th>Phase 3</th>
<th>Management of Risk</th>
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<tbody>
<tr>
<td>Full-service provider of population health services</td>
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<tr>
<td>Offer insurance products direct to the market or partner with major payers to manage professional or global risk</td>
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<td>Commoditize products and services direct full risk-contracting with employers</td>
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<td>Advanced benefits designs</td>
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Care Management Fees

- Fees paid by the health plan to physicians for the provision of care management services
  - Typically risk-adjusted and paid on a PMPM basis
- Requires critical mass of patients to be effective
- Should be done in conjunction with a shared savings program
- Part of medical expenses or administrative expenses?

**Commercial**

$3 PMPM

It really depends on what is included in the CM Fee

**Medicare Advantage**

$20 PMPM

Typical Care Management Fee Range
Shared Savings: Upside Only

Shared savings is split with the health plan and is subject to quality metrics.
Shared Savings: Upside and Down Side

- **Shared Loss**
- **Shared Savings**

Shared savings or loss is split with the health plan.

- Target Spend
- Downside Risk
- Upside Risk
Professional Risk

Note: Only top 4 categories of health spending displayed.
Full and Global Risk Contracts

**Full Risk**
- Capitation for Institutional and Professional Services
- Medical Group and Hospital often share surplus and deficit in risk pool

**Global Risk**
- Single entity receives all funding and pays all claims
Regulatory Issues

- States regulate risk bearing entities.
- Know your state requirements - they vary widely.
  - Knox-Keene Health Care Service Plan Act of 1975 (California)
  - New York required the Department of Health to establish a program governing the approval of ACOs
  - Massachusetts requires all Risk Bearing Provider Organizations (“RBPO”) to register with state agencies
    - Provider organizations that take on significant risk must fall under the DOI oversight even under alternative payment models.
Models Vary by Product Lines

- Medicare, MA, Medicaid, Managed Medicaid and Commercial products have unique characteristics, varying payment models and per capita healthcare resource consumption rates and distinct approaches to population management.
- Within each of these lines of business, there are diverse subpopulations.
- Providers must understand the different nuances and program types when considering risk bearing within and across different product lines and subpopulations.
Health Insurance Coverage by Type
Each Organization’s Mix May Look Different

Private Plans: 258 M
Traditional Medicare: 35 M
Traditional Medicaid: 20 M

Private Health Plan Enrollment by Type:
Total Enrollment = 258 Million

- Individual Non-Group 17%
- Employer Group Risk & FEHBP 8%
- Employer Group ASO 23%
- Medicare Advantage 45%
- Managed Medicaid

Source: Mark Farrah and Associates, 2015. Note, enrollment may be counted in multiple products, therefore inflating total enrollment.
Note: The current uninsured rate is estimated at 11.9% of the US Adult population, Gallup, 2015
Enrollment Changes 2014 to 2015
How Has Your Organization’s Payer Mix Changed?

1Q 2014-1Q 2015 Percent Change in Enrollment by Private Plan Type

<table>
<thead>
<tr>
<th>Private Plan Type</th>
<th>Percent Change</th>
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<tbody>
<tr>
<td>Individual Non-Group</td>
<td>37%</td>
</tr>
<tr>
<td>Employer Group Risk &amp; FEHBP</td>
<td>-7%</td>
</tr>
<tr>
<td>Employer Group ASO</td>
<td>1%</td>
</tr>
<tr>
<td>Medicare Advantage</td>
<td>8%</td>
</tr>
<tr>
<td>Managed Medicaid</td>
<td>35%</td>
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**Product Differentiation when Assuming Risk**

- Understanding an organization’s payer mix is integral to the foundational strategy of moving into risk models.
  - Does the organization have prior experience in risk?
  - Does the organization have a self-funded employee health plan?
  - Does the organization have a predominance of a certain payer or product type, e.g., Medicare, Medicaid, etc.

- While it may add administrative complexity to the risk-taking arrangement, separate agreements or parameters for separate products and types (even with the same carrier) help to mitigate risk.
Medicare
Why Is Value More Important Now?

Medicare’s Move to Payment for Value Accelerates

- **2016**
  - All Medicare FFS (Categories 1-4): 30%
  - FFS linked to quality (Categories 2-4): 85%
  - Alternative payment models (Categories 3-4): 50%

- **2018**
  - All Medicare FFS: 50%

Source: www.cms.gov
Medicare Payment Taxonomy Framework

**Category 1**
- Traditional FFS, volume driven, no link to quality or efficiency

**Category 2**
- FFS linked to quality
- At least a portion of payments vary based on quality or efficiency, e.g., hospital value-based purchasing, physician value-based payment modifier

**Category 3**
- Alternative payment models built on FFS architecture
- Some payment is linked to effective management of a population or an episode of care. Opportunities for shared savings or two-sided risk, e.g., MSSP ACOs, bundled payments

**Category 4**
- Population-based payments
- Payment is not directly triggered by service delivery, so volume is not linked to payment, e.g., eligible Pioneer organizations in years 3 to 5.
Medicare ACO Models

**Pioneer**
- Offers the option of 5 payment arrangements, which share savings and losses of 50 to 75 percent (1 option that has 1 year of 1-sided, all other 2-sided risk)
- Savings and losses are subject to MLR/MSR of option chosen
- Population based payment starting in year 3 for qualifying organizations

**MSSP**
- Upside Risk only in Track 1.
- Upside and Downside risk in Tracks 2 and 3
- 50 to 75 percent shared savings/losses (as applicable) above MLR/MSR
- Eligible organizations may elect the Advance Payment Model or ACO Investment Model (for rural and underserved areas)

**Next Generation**
- Track one has 80 percent sharing rate for performance years 1-3 and 85% for performance years 4-5
- Track two has 100% risk for Part A and Part B expenditures in each year
- Has a PMPM option
### Medicare Shared Savings Program

#### Track 1
- **Upside Risk Only**
- **Shared Savings of 50 Percent**
- MLR/MSR of 2 to 3.9 percent based on number of beneficiaries
- **10 Percent Savings Cap**
- Minimum Attribution: 5,000

#### Track 2
- **Upside and Downside Risk**
- **Shared Savings/Loss Rate of 60%**
- (i) no MSR/MLR; (ii) symmetrical in 0.5% increments between 0.5% - 2.0%; (iii) symmetrical and varied based upon number of assigned beneficiaries
- **15 Percent Savings Cap/5 to 10 Percent Loss Cap**
- Minimum Attribution: 5,000

#### Track 3
- **Upside and Downside Risk**
- **Shared Savings/Loss Rate of 75 Percent**
- (i) no MSR/MLR; (ii) symmetrical in 0.5 percent increments between 0.5 to 2.0 percent; (iii) symmetrical and varied based upon number of assigned beneficiaries
- **20 Percent Savings Cap/15 Percent Loss Cap**
- Minimum Attribution: 5,000
Next Generation ACO

**Track 1**
- Upside and Downside Risk
- Shared Savings of 80 Percent for Years 1-3; 85 Percent for Years 4 to 5
- No MLR/MSR
- 15 Percent Savings/Loss Cap in all Years
- Minimum Attribution: 10,000

**Track 2**
- Upside and Downside Risk
- 100 Percent Risk for Part A and Part B Expenditures
- No MLR/MSR
- 15 Percent Savings/Loss Cap
- Minimum Attribution: 10,000
CMS ACO Models

- Benchmark in MSSP is based on historical 3 years of spending data, risk adjusted using Medicare HCC.
- Next Generation employs a similar methodology, although with regional adjustment and plans to transition away from emphasizing historical expenditures.
- Clearly delineated methodology, with several options available based on provider’s degree of risk acceptance/aversion.
- Unlike commercial carriers, programs are very structured, not negotiable - has its benefits, e.g., you know how the benchmarking methodology is set; and drawbacks, e.g., inflexible/can’t be changed based on provider needs.
Risk Adjustment

- The CMS-HCC prospective risk adjustment models are used to calculate the ACO’s assigned beneficiary population’s risk scores for the benchmark years, which are used in calculating the historical benchmark.

- Changes in the ACO’s risk score between benchmark years 1 and 3 are used to trend forward benchmark year 1 expenditures.

- Similarly, changes in the ACO’s risk score between benchmark years 2 and 3 are used to trend forward benchmark year 2 expenditures.
Risk Adjustment

HCC Becomes Increasingly Important with Degree of Risk

- Hypothetical example of individual risk score
  - Beneficiary is male, age 77, with the chronic conditions: congestive heart failure ("CHF"), diabetes with complications, and chronic obstructive pulmonary disease ("COPD")
  - Risk adjustment model coefficients:
    - Male age 77 = $5,100
    - CHF = $3,900
    - Diabetes w/ comp = $3,300
    - COPD = $3,700
  - Beneficiary’s predicted expenditures are $16,000
  - Average expenditures for all beneficiaries are $10,000
  - Beneficiary’s risk score = $16,000/$10,000 = 1.6
Risk Adjustment

As degree of risk increases, risk adjustment becomes increasingly important. In Medicare Shared Savings, it impacts the provider’s benchmark; and in advanced risk (capitation) for MA, it impacts the payment to the Plan and subsequent capitation to the provider organization.
Patients that have received at least one primary care service from a primary care physician ("PCP") in the ACO

- Attribute to the ACO if the PCPs in the ACO provide the plurality of primary care services for the beneficiary
- PCP includes General Practice, Family Medicine, Internal Medicine, Geriatric Medicine, FQHC or RHC

Patients that have not received a primary care service from any PCP

- A beneficiary is assigned to an ACO if the beneficiary receives a plurality of his or her primary care services from specialist physicians and certain non-physician practitioners
- Non-physician practitioners include nurse practitioners, clinical nurse specialists, and physician assistants

Attribution: Medicare ACOs
Attributed Members

15% of Commercial Members are attributed to a provider under an alternative payment contract such as ACOs or PCMHs (2014)

11% of Medicare Beneficiaries are attributed to a provider in the MSSP or Pioneer ACO programs (2015)

Source: Catalyst for Payment Reform and Oliver Wyman
THE CAMDEN GROUP | 10/05/2015
Commercial Products and/or Private Plans with Government Products
40% of all commercial payments to hospitals and doctors are “value-based.” Here’s how it breaks down:

- Full-risk capitation: 15%
- Fee-for-service + incentive: 12.8%
- Other: 7.5%
- Fee-for-service + shared savings: 2%
- Partial capitation: 1.6%
- Shared risk: 1%

Source: Catalyst for Payment Reform
Why is Value More Important Now?

The Health Care Transformation Task Force

- Industry consortium that brings together patients, payers, providers, and purchasers
- Committed to having 75 percent of their respective businesses operating under value-based payment arrangements by 2020
Risk-Based Value Oriented Payments: Commercial

Of the 40 percent of value-based payments, the majority are “at-risk.”

53 Percent Value Oriented Payments “at risk”

47 Percent Value oriented payments “not at risk”

Source: Catalyst for Payment Reform
THE CAMDEN GROUP | 10/05/2015
Commercial Carrier Programs

Often a Combination of Methodologies

- Some level of formal PCMH accreditation may be required
- Care Management fees paid on a PMPM basis are negotiable and often deducted from any savings (also negotiable)
- Number of attributed lives requirement may be lower (e.g., 1,500)
- Quality metric performance and STAR rating (MA) are important components.
Product Differentiation in Commercial when Assuming Risk

- The mix of members within the population may vary from what the carrier assumed, subjecting providers to substantial mix risks.
- The profiles in the individual population will range from:
  - Those not previously seeking insurance (young invincibles)
  - Medically underwritten
  - Previously uninsured
- The composition and size of the small group population for a carrier could vary significantly depending on the size of the groups enrolled and the prevalence of small group self-insured products
Commercial Risk

Full or Partial Risk

Provider’s Own Self-Funded Group

Direct to Employer Contracting

Professional Capitation

Full Risk or Global Risk
Medicare Advantage

- Enrollment growth, attractive option for health systems to:
  - Partner with payers - private branded plan
Medicare Advantage

- Many health systems starting their own plan, predominantly in the MA space.
- Significant capital and infrastructure requirements.
- Compete with the large, national carriers.
- Provides greatest risk/reward.
- Requires culture change

What is your strategy?
Managed Medicaid

- Managed Medicaid plans often willing to share risk and/or capitate providers.
- Shared Savings/ACO, partial and full capitation alternatives.
- Need to understand the differences in populations and sub-populations, e.g., pediatric population, low income adults, disabled individuals, dual eligibles, etc.
- Many organizations taking risk for Medicaid often have a high volume of Medicaid enrollees and experience caring for this population.
Commercial/Private Contracting Considerations

- Which products are included? Individual, exchange, SHOP, employer group risk, self-funded, etc.
- Is this a private plan with a MA or Managed Medicaid product?
- 3 R’s
  - Risk adjustment
  - Re-insurance
  - Risk corridors
- If pursuing partial capitation, what are carveouts (e.g., pharmacy, mental health, transplants, etc.)
- If shared savings, how are benchmarks established?
- What is attribution process?
**Attribution**

Non-HMO attribution can be handled in several ways:

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<th>Type</th>
<th>Description</th>
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<tr>
<td>Prospective</td>
<td>Organizations are provided with a list of attributed members at the <strong>beginning of a performance year</strong>; attribution is based on data from the patients’ use of services in the previous year.</td>
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<tr>
<td>Performance Year</td>
<td>Patients are attributed to organizations at the <strong>end of the year</strong> based on patients’ use of care during the actual performance year.</td>
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<td>Hybrid</td>
<td><strong>Preliminary prospective assignment methodology</strong> with final retrospective reconciliation where there is prospective attribution initially; followed by <strong>retrospective reconciliation</strong>.</td>
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Implementing Capitation-Based Contracts

- Provider orientation - when to refer
- How is the eligibility and benefit information delivered?
- Knowing your experience and cost:
  - Whose data do you use and how accurate is it (e.g., actual vs. actuarial data)?
  - Fixed capitation (e.g., age/sex) vs. Percent of premium?
  - Covered vs. not-covered? Experimental procedures, carve-outs, and out of area
  - How to pay for non-covered services?
  - How is the capitation distributed?
Implementing Capitation-Based Contracts

- Tracking and gathering encounter data and sharing with providers to change behavior
- Termination clause to deal with: continuing care obligations, communication to members, medical record transfer, not to compete.
- Bonus pools for quality of care, patient satisfaction, and administrative compliance.
- Policies for use of other specialists and ancillary providers.
Medicaid
State Medicaid Programs with Alternative Payment Models

Health Home Models

ACO Models

PCMH Models

DSRIP Models

Source: Kaiser Family Foundation, 2015
Care Model Execution and Clinical Cultural Transformation
“The Vise”

- Balance between purchasers and providers
- Baby Boomers- getting older and demanding the most (not necessarily the best)
- Obesity up 60 percent in 10 years
- Increased incidence of chronic disorders such as heart disease, diabetes, asthma, and mental health conditions
“The Vise”

- Continued rising costs
  - New technology
  - Higher utilization
  - Higher charges

- De-linking of healthcare coverage from employment
  - More uninsured
  - More individuals seeking coverage (high deductible, catastrophic coverage only)
  - Defined contribution plans?
Current Trends

- More options/more choices

“Tell us what you want and our actuaries will price it for you.”

- Higher deductibles
- Higher co-pays, or co-insurance
- More tiers in drug benefits?
Reality Check

- If all you do is rearrange the deck chairs.................................the ship still hits the iceberg
- Must change how care is delivered to have a positive change in outcomes and produce value
Care Management is the Common Thread
Linking the Patient Through Every Setting
Pathway to Value
Care Management

“A collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality cost-effective outcomes.”

- The Case Management Society of America
Across the Continuum

Care Management

...a patient-centered, assessment-based, interdisciplinary approach to integrating healthcare with the goals of improving patients' health status while reducing the cost of care

- Patient and caregiver engagement/education
- Care plan development
- Medication management
- Advance care planning
- Care coordination
- Biopsychosocial consideration
- Information transfer, communication, and collaboration among providers and care settings

Source: The Camden Group
Rethinking Our Organizational Orientation
Focus Areas

Where Are The Opportunities?

- Preventive health, gaps in care
- Diabetes
- Heart failure
- Asthma – adult and pediatric
- Readmission prevention
- Behavioral health
- Care transitions between settings

- Utilization management (reducing unnecessary ED utilization)
- Care coordination/navigation
  - Transportation
  - Referrals
  - Community resources
  - Health education
Care Settings

Where Are Patients Managed?

- Comprehensive care coordination across the continuum
  - PCP
  - Ambulatory care management (embedded and non-embedded)
  - Inpatient case management including hospitalists
  - ED case management
  - Sub-acute facilities’ resources
  - Behavioral health
  - Home health
  - Community linkages
  - Long-term acute care hospital/skilled nursing facility (“SNF”)
  - Urgent care centers
  - Emergency medical services triage
  - Outpatient clinics (PCMH, clinics)
Care Management Functions

- Education/Self-management
- Care coordination across networks
- Support to patient and caregivers
- Referral to community-based resources
- End-of-life support
  - Hospice referrals
  - Advanced directives
Who, Where, and When?

Patient identification through:
- Stratification
- Clinical qualifiers
- Disease states
- Frailty
- Coordination needs

Right Patient

Right Place
Patient engagement at:
- Home
- Hospital, SNF
- Care transitions
- Telephonic

Right Time
Patient outreach when:
- New patient
- After PCP visit
- 30 days post-acute
- New diagnosis
- New prescription

Right Role
Patient care delivery by:
- Appropriate individual, based on training
- Care team member with expertise who fulfills patient needs
Risk Stratification Methods
The Triple Aim™

Risk Stratification tools can help achieve the Triple Aim™ by identifying “at risk” populations and enabling providers to match them up with the appropriate level of intervention to improve clinical outcomes and maintain and even reduce healthcare costs.
Why Is It Important?

- Organizations assuming risk for populations based on overall performance
- Majority of healthcare dollars are spent by a small percentage of population
  - 80/20 rule
- Risk stratification helps care managers organize their workflow and task activities
- Focus high intensity services on high risk populations
- Rapid increase in the need to risk stratify
  - Healthcare reform
  - Rising costs
  - Prevalence of chronic diseases
Population Care Management: Risk Categorization

- **High-risk Patients**: 5%
  - One complex illness, multiple co-morbidities

- **Risk-rising Patients**: 15 - 30%
  - Chronic, aging, chronic condition - unmanaged

- **Low-risk Patients**: 65 - 80%
  - Healthy or chronic condition – managed
Triggers or Patient Criteria

- Automatic notification to care managers based on specific, pre-defined criteria (usually based on claims or clinical data)
- Inpatient automatic triggers can include:
  - Patients with extended LOS (> 5 days)
  - Patients with more than 1 unplanned admission within the past 90 days
  - Patients with high intensity of service: ventilators, dialysis
  - Age > 75 years
  - Admission to a long-term care facility
  - Certain high-risk diagnoses (both primary and secondary) including: heart failure, COPD, renal failure, stroke, complex cancers, dementia, or severe mental health issues
  - High risk units (ICU, step down, transplant)
  - Any admission or ED visit for a patient on care management (“CM”)
Triggers or Patient Criteria

- Outpatient automatic triggers can include:
  - Chronic diseases with potential down the road complications: diabetes, asthma, hypertension, coronary heart disease
  - Triggers to indicate poor self-maintenance such as HbA1c > 10
  - Patients with more than 3 chronic conditions
  - Patients with more than 7 medications
  - Patients with history of frequent ED visits and admissions
  - Mild to moderate mental health issues
Risk Stratification Process

- Identify the population to manage
- Define criteria associated with each risk level
- Generate lists of patients according to criteria
- Evaluate lists for appropriateness and refine as necessary
- Develop targeted care management programs and interventions
- Educate providers on proper care management referrals
The “New Model” for Risk Stratification

- Evaluate data coming from claims files or the EMR, including lab results and medications. Below are commonly used indicators or metrics in risk stratification. They are usually weighted and then a calculated score is assigned to the patient indicating risk level:
  - Age
  - Gender
  - Costs
  - Diagnosis codes or DRG
  - Frequency of utilization (e.g., hospitalizations, ED visits, PCP visits)
  - Number of medications
  - Variability in providers (e.g., number of unique PCPs)
The “New Model” for Risk Stratification

In addition to claims data, the following can determine risk:

- Clinical judgment
  - Ask team members to refer appropriate patients to CM
  - Define the CM referral process
  - Supply a list of “Referral Criteria” or “Risk Criteria” as a guide

- Survey or assessment data
  - Beneficial to have psychosocial or qualitative data as part of the risk stratification formula
  - Health Risk Assessment (“HRA”) or something similar to collect data
Data Infrastructure
Output of Risk Stratification Tools

- These robust systems usually provide patient profiles with metrics such as these:
  - Risk score
    - Percentage format (e.g., patient has a 98 percent chance of high utilization in the next 12 months)
    - Numerical format (e.g., patient is ranked with a score of 4.5 out 5.0)
    - Tiers (e.g., high risk, moderate risk, or mild risk)
  - Total costs
    - Total inpatient costs (by condition, by specific time periods)
    - Total outpatient costs (by condition, by specific time periods)
    - Total pharmacy costs (by condition, by specific time periods)
Output of Risk Stratification Tools

- **Utilization**
  - Total hospital admissions within a time period (with average length-of-stay)
  - Total ED visits within a time period
  - Total number of ambulatory visits within a time period

- **Disease-based registries**

- **Total number of comorbid conditions**

- **Total number of filled medications**

- **Total number of providers (by provider type)**
Apply Risk Stratification to the Care Model

Risk Stratification Tool
- Consolidate data from CDR, EMR, DWH
- Analyze claims and clinical data
- Stratify patients by risk levels
- Refer to appropriate level of care

High Risk Care Management
Complex Care Management
Disease Management
Preventive Health
Suggested Interventions for Different Risk Levels

- **High Risk Care Management**
  - Care Manager calls 3 times per week
  - In-person, in-clinic visit with patient
  - Work in partnership with practices and providers
  - Early intervention for urgent symptoms – refer to urgent care or hospitalists

- **Complex Care Management**
  - Care Manager calls 2 times per week
  - Early identification of patients requiring medical intervention
  - Symptom and disease education

- **Disease Management**
  - Interactive Voice Response (“IVR”) outreach
  - Care Manager calls when triggered by IVR
  - Care coordinator calls 1 time a month, can refer to Care Manager

- **Preventive Health**
  - Automated clinical workflow
  - Letter generation
  - Patient education materials
Care Management

Transitional Care Management
- Inpatients at highest risk for readmissions, avoidable ED utilization, and poor outcomes.
- Discharge and transitions plan. Clean hand-off to next level. Close follow-up.

Home Care Management
- Chronically ill, highest risk, frail.
- Care management team, palliative care, and end-of-life.
- Patients have mental, social, financial limitations to care.

Complex Case Management
- Multi-disciplinary team to address complex disease management.
- High-risk patients with barriers to compliance and gaps in care
- Plan of care including self care and patient engagement.

Disease Management
- PCMH manages chronic disease with outreach, notifications, referrals, and quality metrics.

Wellness/Lifestyle Management Accountable Communities
Staffing Ratios

Variables to consider include:

- Patient population
- Encounter frequency
- Interventions
- Length-of-stay in program
- Location of services
- Geography
- Team composition
- Technology support
- Other resources

### Benchmarks

<table>
<thead>
<tr>
<th>Ratios</th>
<th>Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 3 Patients</td>
<td>2 - 5%</td>
</tr>
<tr>
<td>Tier 2 Patients</td>
<td>5 – 8%</td>
</tr>
<tr>
<td>Tier 1 Patients</td>
<td>~90%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Staffing</th>
<th>Panel Sizes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitalist</td>
<td>18-22</td>
</tr>
<tr>
<td>Primary Care Physician</td>
<td>1,500-2,500</td>
</tr>
<tr>
<td>Inpatient Care Manager</td>
<td>25-50</td>
</tr>
<tr>
<td>In-home Care Manager</td>
<td>25-100</td>
</tr>
<tr>
<td>Telephonic Care Manager</td>
<td>100-250</td>
</tr>
<tr>
<td>Care Coordinator</td>
<td>250-500</td>
</tr>
<tr>
<td>Social Worker</td>
<td>50-150</td>
</tr>
<tr>
<td>Clinical Pharmacist</td>
<td>150-500</td>
</tr>
</tbody>
</table>
Who, Where, and When?

Patient identification through:
- Stratification
- Clinical qualifiers
- Disease states
- Frailty
- Coordination needs

Patient engagement at:
- Home
- Hospital, SNF
- Care transitions
- Telephonic

Patient outreach when:
- New patient
- After PCP visit
- 30 days post-acute
- New diagnosis
- New prescription

Patient care delivery by:
- Appropriate individual, based on training
- Care team member with expertise who fulfills patient needs
Design and Align Workflows

- Compose a workflow team with representation from every care team member.
- Draw workflows outlining how a patient moves through the system. Processes might include:
  - Referral and enrollment
  - Escalation paths
  - Discharge and transition
- Address and outline:
  - Roles and responsibilities
  - Interventions and procedures
- Coordinate processes with all providers and care team members.
- Share clinical information and communicate with entire care team.
- Use technology systems to support workflows.
Design and Align Workflows

**Push/Pull Referrals**
- Educate referral sources which may include data, providers, and case managers
- Establish a process via telephone, fax, technology

**Assess Needs**
- Assess patients’ needs (ADLs, IADLs, PHQ-9)
- Consider scoring and tracking progress
- Identify frequency of assessments
- Develop protocols for interventions based on assessment results

**Care Plan**
- Set goals with the patient and caregivers
- Develop action items and interventions
- Identify barriers
- Track progress

**Follow-Up**
- Track progress
- Adjust care plan as needed
- Continually assess patient for right level of care and clinical program
Design and Align Workflows
One Patient Care Plan
## Communication Plan

**Internal Communication Plan**

- Provide education on care model changes, new care team members, updated workflows, resources
- Anticipate questions patients and providers are going to ask
- Ensure staff and providers aware of all the programs offered along the continuum
- Create a process for staff and providers to refer patients to appropriate programs
- Encourage providers to collaborate
- Solicit feedback from providers

**External Communication Plan**

- Consider deploying liaisons to facilitate communication
- Consider a branding campaign
- Align published patient materials and distribute
- Establish relationships with key providers in the network
- Create a process for patients and partners to refer to appropriate programs
- Encourage partners to collaborate
Pathway to Population Health Management

Care Management

Which of the following is not essential to the care management process?

A. Assessment
B. Planning
C. Facilitation and advocacy
D. EMR
E. Collaboration
Planning for Population Health Management

Patient Engagement

“Actions individuals must take to obtain the greatest benefit from healthcare services available to them.”

- The Center for Advancing Health

- Focus on behaviors of individuals relative to their healthcare that are critical to health outcomes
- Individual synchronizes information and professional advice with their own needs, preferences, and abilities
Patient Engagement Paradigm Shift

From
- Telling patients what to do
- Transfer of information
- Compliance

To
- Listen, problem solve, and collaborate
- Developing confidence
- Building capability
Common job titles for “Care Managers” include:
- Care/Case Manager
- Care Coordinator
- Health Navigator
- Patient Coach

Care Managers have clinical backgrounds and are typically:
- Registered Nurses ("RN")
- Licensed Vocational Nurses ("LVN") or Licensed Practical Nurses ("LPN")
- Social Workers ("SW")

Support team members
- Medical Assistants ("MA")
- Non-clinical Staff
Rethinking The “Care Team”
Building a Plan of Care
Clinical Protocols

- Acute Myocardial Infarction
- Substance Abuse
- Asthma
- Cancer Screening
- Community Acquired Pneumonia
- Congestive Heart Failure
- COPD
- Depression
- Diabetes
- End Stage Renal Disease
- Hypertension
- Lipid Management
- Low Back Pain
- Osteoporosis
- Pain Management
- Tobacco Treatment
The Patient Care Plan

- Capture patient preferences, patient goals, and action items (a standardized template should be used)
- Develop in collaboration with the patient, family, caregiver(s), patient’s provider(s), and care managers
- Update frequently based on changes in the patient’s health status and goals
- Share with members of the patient’s interdisciplinary care team
- Share with the patient, family, and caregiver(s) to align expectations and goals and available in the appropriate language and literacy level
  - Attach patient educational materials, as appropriate
The Patient Care Plan

Key Components

- Patient name and demographics
- Caregivers, including names and contact information
- Provider listing, including names and contact information
- Next doctor appointments
- Insurance information
- Immunizations
- Religion
- Culture
- Language

- Preference for learning
- Advance directives information
- Medication list
- Allergies
- Date of last ED visit and last inpatient admission

Action Plan

- Problems
- Goals
- Barriers to goals
- Interventions and action items
Action Plan

- **Problems**
  - What diagnoses, conditions, and issues are the patients facing today? These do not need to be ICD-10 codes but rather real concerns the patient has
  - Example: At risk for falls

- **Goals**
  - List achievable goals, something you can check off as complete
    - Example: Change home setting to reduce risk of falls

- **Barriers to goals**
  - What is in the way of the patient achieving this goal?
    - Example: Patient is not physically able to move furniture
Action Plan

- Interventions and action items
  - List the tangible action item(s) that need to be completed to meet and achieve the goal(s), including who is accountable and when
  - Examples:
    - Ask cleaning lady to remove all throw rugs on next Wednesday
    - Ask son-in-law to purchase and replace all dead light bulbs in the hallways and rooms by end of the month
Aligning Incentives
Effective Design of Incentives is Integral to Change
Provider Value Equation

\[ V = Q + S \]

\( V \) (Value) = \( Q \) (Quality) + \( S \) (Service)
Which Factors Are Important to Success?

- **Revenue**: HCC/RAF
- **Expense**: Manage utilization and appropriate sites of care; implement care model redesign
- **Quality**: Clinical metrics and outcomes
- **Service**: Patient experience
Holistic Approach to HCC Programs

- Properly incentivize and educate provider network to fully capture diagnoses to reflect accurate risk scores.
  - Engage Patients
  - Provide Comprehensive Quality Care
  - Proper Documentation
  - Timely and Complete Submission to Plan/ CMS
  - Valid and Accurate Coding
Domains of Quality and Service

- **Process**: The percentage of patients with chronic stable coronary artery disease who were prescribed lipid-lowering therapy.

- **Access**: The percentage of members 12 months to 19 years of age who had a visit with a primary care practitioner in the past year.

- **Outcome**: The risk-adjusted rate of in-hospital hip fracture among acute care inpatients aged 65 years and over, per 1,000 discharges.

- **Structure**: Does the health care organization use computerized physician order entry.

- **Patient Experience**: The percentage of adult patients that reported their doctors always communicated well.
Why Is It So Difficult?

Lack of consistent manner to measure quality.

Physicians asked to comply with different measures depending on the payer.

### United Healthcare PCP Incentive Program

<table>
<thead>
<tr>
<th>Health Care Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication Safety Monitoring: ACE or ARB Therapy, Digoxin, Diuretics</td>
</tr>
<tr>
<td>Breast Cancer Screening: Mammogram (42 to 69 years)</td>
</tr>
<tr>
<td>Cervical Cancer Screening: Pap Test (24 to 64 years)</td>
</tr>
<tr>
<td>Diabetic Care: HbA1c Test (18 to 75 years)</td>
</tr>
<tr>
<td>Diabetic Care: LDL-C Screening (18 to 75 years)</td>
</tr>
<tr>
<td>Diabetic Care: Nephropathy Screening (18 to 75 years)</td>
</tr>
<tr>
<td>Pharyngitis: Abx and Group A Strep Test (2 to 18 years)</td>
</tr>
<tr>
<td>URI and No Abx Prescription (3 months to 18 years)</td>
</tr>
</tbody>
</table>

### Anthem Blue Cross Blue Shield Quality In-Sights PCP Program

<table>
<thead>
<tr>
<th>Health Care Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dilated Retinal Exam — Members with diabetes, age 18 to 75, who had an eye exam with an eye care professional during the measurement year or the year prior to the measurement year.</td>
</tr>
<tr>
<td>HbA1c Test — Members with diabetes age 18 to 75, who received 2 HbA1c tests, at least 3 months apart, during the measurement year.</td>
</tr>
<tr>
<td>LDL-C Test — Members with diabetes, age 18 to 75, who received an LDL-C test during the measurement year.</td>
</tr>
<tr>
<td>Appropriate Medication Use - Members with persistent asthma, age 2 to 56, who had at least one dispensed prescription for inhaled corticosteroids, nedocromil, cromolyn sodium, leukotriene modifiers, or methylxanthines in the measurement year.</td>
</tr>
<tr>
<td>Well Child Visits — Members, age 3 to 5, who received a well care visit during the measurement year.</td>
</tr>
<tr>
<td>Adolescent Well Care Visits — Members, age 11 to 18, who received a well care visit during the measurement year.</td>
</tr>
<tr>
<td>Members, age 2 to 18, who were diagnosed with pharyngitis or tonsillitis, prescribed an antibiotic, and received a group A streptococcus test for an episode in the measurement year.</td>
</tr>
</tbody>
</table>
Patient Satisfaction

Everyone Is Rating Physicians
Patient Satisfaction

- It is both important to manage your reputation with the multitude of ratings and to measure patient satisfaction internally.
- Some organizations rely on health plan or CMS satisfaction surveys.
- CG-CAHPS or other tested, reliable, and comparable tool is recommended.
- Integrate patient satisfaction into physician compensation.
- Be cautious about interrelationship between clinical quality metrics and patient satisfaction.
Funds Flow

- Once you have achieved savings or “profit”, how are the funds distributed back to the providers of care that are working to improve the delivery system?
- Depending on the structure, your organization may not have the authority to distribute back to individual providers, diluting the impact of the incentive.
- Funds flow decisions should be made **BEFORE** there is savings to be shared and criteria for distribution clearly delineated and communicated in advance.
Shared Savings: Funds Flow Model Decision Points

- **A**: Reinvest in CIN infrastructure or offset operating expenses?
- **B**: Shared Savings $$
  - **C**: PCP Pool or Percentage
  - **D**: Specialist Pool or Percentage
  - **E**: Hospital Pool or Percentage
    - **F**: Determine allocation of savings
      - **G**: Define criteria qualifications by Pool
        - **H**: CIN Undistributed Funds Share
          - **I**: Redistribute non-qualifying MDs distributions
            - **J**: Evaluate performance based on quality metrics
              - **K**: CIN Undistributed Funds Share
                - **L**: Redistribute surplus funds from step F
Shared Savings: Funds Flow Model Decision Points Example

1. **Reinvest in CIN infrastructure or offset operating expenses?**
   - 20%

2. **Shared Savings $\$$**
   - PCP Pool or Percentage
     - 45%
   - Specialist Pool or Percentage
     - 35%
   - Hospital Pool or Percentage
     - 20%

3. **Determine allocation of savings**
   - Patient attribution
     - Unique patient contacts

4. **Quarterly Scorecard**
   - Checking or other hurdle criteria

5. **CIN Undistributed Funds Share**
   - 20%

6. **CIN Undistributed Funds Share**
   - 100%

7. **Define criteria qualifications by Pool**

8. **Redistribute non-qualifying MDs distributions**

9. **Evaluate performance based on quality metrics**
   - 4 Patient Experience metrics
     - 8 Quality Metrics

10. **Redistribute surplus funds from step F**

   **STEPS**

   - **A**
   - **B**
   - **C**
   - **D**
   - **E**
   - **F**
   - **G**
   - **H**
If Taking Full or Partial Risk (Capitation)

Physician Reimbursement

- Structure of organization will impact how this is handled.
- For PCPs:
  - Continue FFS with optional withhold
  - Capitation - flat fee by product line; or age/sex Differentiated by product line
  - Percent of premium
- For Specialists:
  - FFS
  - Sub-capitation
Tie in to Physician Compensation

Are Distributions and Reimbursement Aligned with Physician Compensation?

- Make sure incentives that are driving reimbursement and distribution are reflected in individual physician compensation and/or bonus structure.

- Can be extremely challenging with multiple organizations, payers, risk arrangements, and quality/clinical metrics involved.
Aligned Incentives: Physician Compensation

Sample Medical Group Compensation Model Transition

<table>
<thead>
<tr>
<th>Current</th>
<th>Transition Options</th>
<th>Future</th>
</tr>
</thead>
<tbody>
<tr>
<td>98%</td>
<td>95%</td>
<td>20%</td>
</tr>
<tr>
<td>2%</td>
<td>5%</td>
<td>40%</td>
</tr>
</tbody>
</table>

- **Efficiency**: 10% 10%
- **Quality**: 15% 15%
- **Service**: 20% 20%
- **Panel Size**: 20% 20%
- **Value Incentive**: 10% 10%
- **RVUs**: 10% 10%
- **Salary**: 40% 40%
Physician Compensation

Percentage of Total Compensation Tied to Quality (Excluding Patient Satisfaction), 2013-2014

Source: MGMA 2015 Physician Compensation and Production Report
Physician Compensation Under Different Practice Arrangements

Aligned Incentives: Physician Compensation

- Align compensation with organizational vision and goals as well as contractual reimbursement structures
- If “bonuses” or shared savings are paid down from a CIN or risk bearing entity to the TIN level, the purpose of the incentive may be defeated if performance isn’t integrated into compensation at the TIN level.
  - Consider issues associated with fair-market-value of compensation, inability to distribute additional “bonus”
- Effectively aligning incentives is integral to successful behavioral change.
General Requirements for Managing Risk

- Integrated information systems
- Comprehensive utilization management system
- Selected risk sharing partners
- Provider performance review process
  - Quality and outcome measurements, access and availability, patient satisfaction, compliance with policies and procedures, evaluation of Specialists by PCPs
- Adequacy and geographic coverage of network, including hospitals
- Creation and dissemination of physician profiles
  - Referrals to specialists, utilization of ancillary services, inpatient admissions and LOS, use of outpatient facilities, pharmacy cost, patient complaints and requests for second opinions, patient panel
Other Considerations for Success
How Do you Define Leadership in Your Organization?
Evolving Leadership Requirements

Fee-For Service

- Hospitalist and Case Management
- Throughput
- Patient Safety

“Lean” Management Vision Seek Growth

Transition

- Reduce Re-admissions
- Physician Enterprise Restructure
- Clinical Co-management

Change Management Communication

Fee-for-Value

- ACO
- Clinical Integration
- Care Management
- Medical Home
- Collaboration Transparency

THE CAMDEN GROUP   |   10/05/2015
Rethinking Our Organizational Orientation
Creating an “Integrated” Culture

- Patient-Centered
- Continuous Improvement
- Partnership/Collaboration/Trust
- Transparency

Accountability
Clinical Integration – Aligning to Achieve the “Triple Aim”

- Patients
- Payers
- Hospitals
- Physicians
- Post-Acute and Other Community Providers

Enhance Health

- Improve Experience of Care
- Reduce Cost
- Aligned Incentives
- New Care Delivery Models
- Health Information Technology

Aligned Incentives

Care Management
Pyramid of Success

- Commercial:
  - HMO
  - PPO
  - Direct to Employers
  - Insurance Exchange
  - Bundled Payment

- CMS:
  - ACO-MSSP
  - Pioneer ACO
  - Medicare Advantage
  - Bundled Payment

- Dual Eligibles:
  - HMO
  - Bundled Payment

- Medicaid:
  - HMO
  - FFS

Access Points:
- (UCC, FQHCs, ED, Health Plans, Physician Offices, Retail Clinics, etc.)

Levels:
- Defined Population
- Primary Care
- Medical Specialists
- Surgical Specialists
- Community Hospital
- Tertiary
- Quaternary
Clinical Integration Building Blocks

- Improved Quality and Access
- Clinical Integration
- Reduced Costs and Waste

**Finance/Managed Care**
- Value-based Payment Models
- Funds Flow Distribution

**Delivery Network**
- Expand Primary Care Base
- Strengthen Partnerships Along Continuum
- Define Membership Criteria

**Care Model/Information Technology (“IT”)**
- Care Management
- Population Health Management
- Clinical Data Repository
- Data Analytics

**Organizational Structure**
- Physician Leadership
- Entity Formation
- Change Management
- Establish Governance
Business Planning Considerations

**Market**
- Target population
- Assessment of market size
- Feasibility of attracting market
- Marketing approach

**Structure**
- Joint venture partners, if any
- Ownership structure
- Governance

**Regulatory**
- Approvals and licensure required
- Timing

**Financial**
- Cash reserve requirements
- Expected premiums
- Financial projections
- Capital requirements

**Operational**
- Capabilities inventory
- Enhancements required
- Outsourcing requirements
Critical Success Factors

- Integrated **clinical management** infrastructure (e.g., care management capability and acute case management with hospitalists)

- **Commit the resources** required for timely and successful execution (capital, IT infrastructure, physicians, network development, human capital/time)

- Create and adhere to a **prioritized operational action plan** for implementation, with clear timeframes, measures, and accountabilities

- **Disseminate actionable and meaningful data** quickly and transparently to drive decision-making and accountability

- Develop a **unified culture that breaks down silos** and achieves buy-in through collaborative decision-making

Questions and Discussion