

Making the Business Case for Value-Based Care:

REAL-WORLD PROVIDER CASE STUDIES SHOW EVIDENCE THAT FOCUSING ON VALUE IS A BETTER BUSINESS MODEL THAN MAXIMIZING VOLUME

March 1, 2018



LEAVITT

PARTNERS

Participants

Panelists

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Moderator

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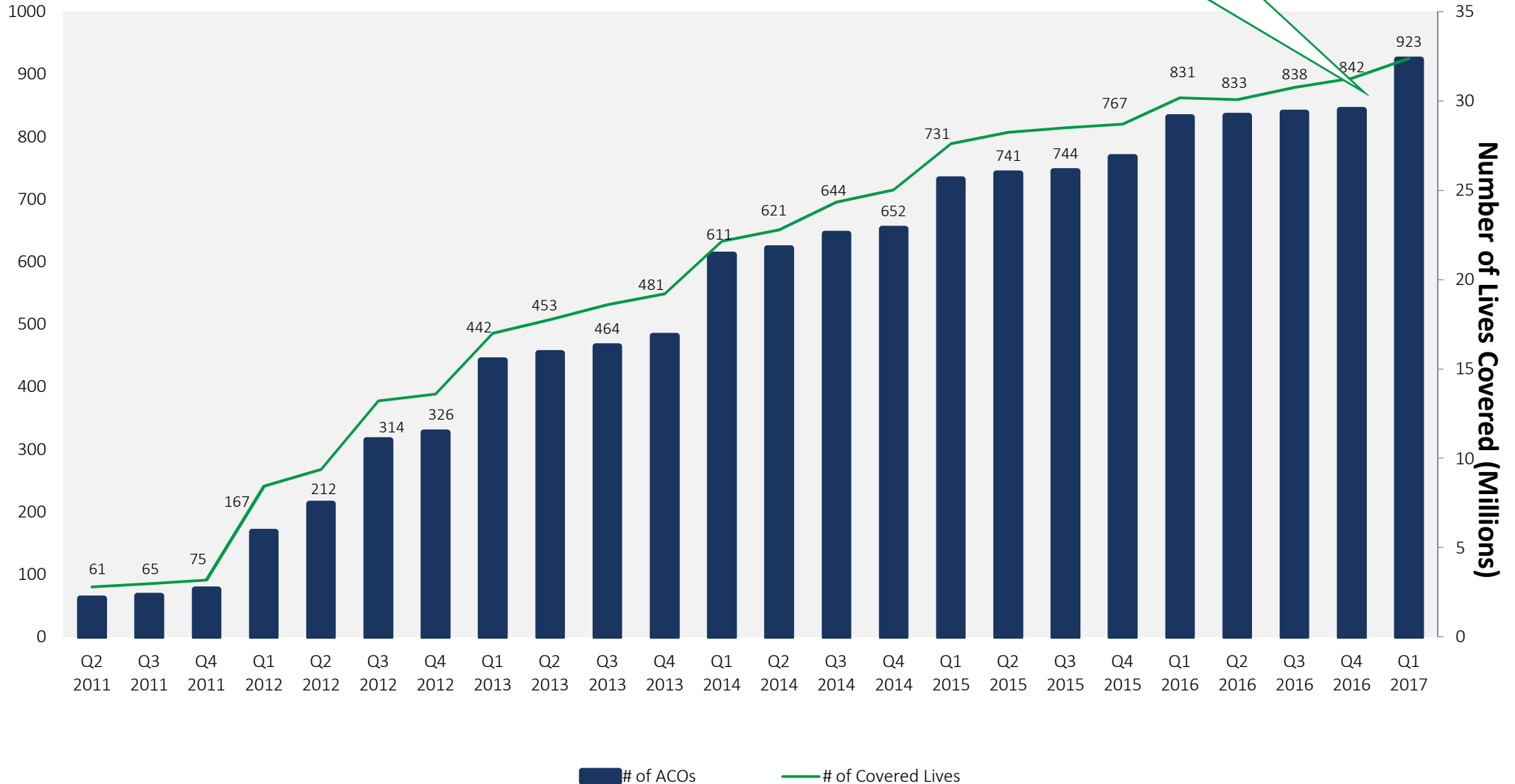
David Muhlestein, PhD JD

LEAVITT PARTNERS; WASHINGTON, DC

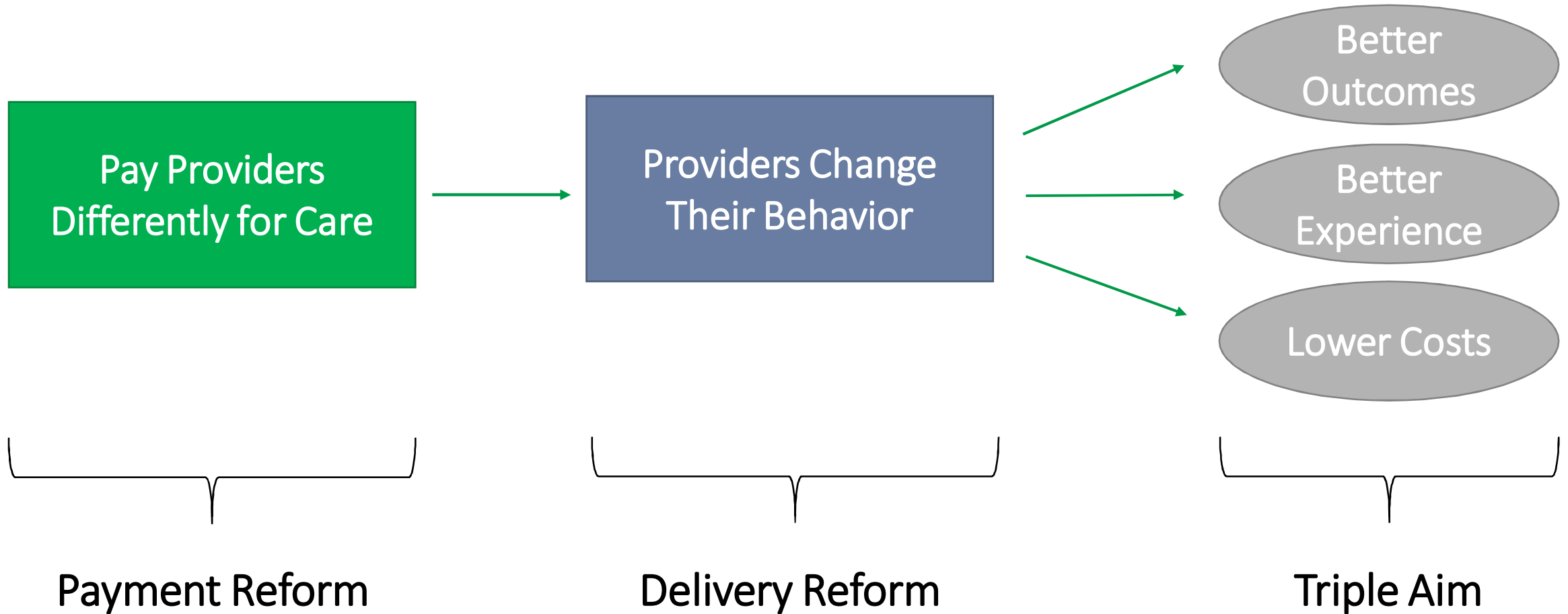
ACO Growth

Number of ACOs

32.4 Million Lives



The *Theory* of Health Care Reform



Aggregating Knowledge: Accountable Care Learning Collaborative

Industry Collaboration



Case Study Briefs

The image shows a stack of case study briefs. The top brief is titled "Home-Grown Solutions for Tracking Total Cost of Care: Arizona Connected Care's Approach" and is dated February 2017. The brief includes a CSB Case Study Brief logo, a title, a date, and sections for Details, Competency, Background, Approach, and About MyHealth First Network (MyHFN).

Details: FINANCIAL READINESS **Category:** FINANCIAL SYSTEMS
Competency: FIR 1.5 Establish and maintain systems to track utilization, revenue, and costs when bearing financial risk

BACKGROUND
 Arizona Connected Care is a physician-driven ACO and was one of the original 27 participants in the Medicare Shared Savings Program (MSSP) starting in April of 2012. The organization struggled in its initial years to generate shared savings and, in 2014, hired a new CEO with experience in care management and risk-sharing arrangements. Under new leadership, it was determined that the ACO needed to adopt a "total cost of care" approach to its clinical strategy by improving its understanding of utilization patterns and the cost implications at both the patient and regional provider levels. After having two average performance years, leadership felt the pressure to justify continued participation in the MSSP but also to prove the long-term potential of the ACO model.

APPROACH
 The ACO had, from the beginning, been engaged in substantive clinical efforts to improve care for patients, but new leadership felt that the individual providers needed broader context and data to see significant improvements. The goal was to help doctors understand what care actually costs both at individual and system level, and how different procedures and pathways related to outcomes. The goal was to move from a system where each doctor was simply trying to do his/her best to one where the decision-making process was data-driven.

For this approach, the ACO first had to ensure that its contracts with its payer partner included data sharing - potentially to a degree to which most insurance companies were not yet accustomed. Fortunately, CMS made claims data available as part of the MSSP and the ACO was able to obtain robust data from the commercial payer partner for the Medicare Advantage population. The next step was to ensure that the ACO had staff that could begin to perform light analysis to get basic system-level statistics like hospital admissions per thousand for their attributed population which would be a decision data analyst. At times, the ACO used outside contractors to handle higher level questions but did so sparingly to avoid making responsibilities to develop the competency internally. To support this new cost analysis efforts, the ACO had to ensure that staff would have adequate computer systems to be able to handle the large number of claims data which required more storage and memory than was existing from prior electronic operations.

Early analysis focused on three main categories of services: 1) hospital admissions, 2) skilled nursing facility (SNF) admissions and 3) specialty visits and procedures. The first category included items that involved admissions that represent opportunities to provide the same or better care in much less expensive settings. One example would be avoiding admitting a patient for intravenous antibiotic administration if the patient could receive the same drug orally or at their residence from a home health provider. Also included in this category were the readmission opportunities that developed with an in-hospital program which justified additional resource investment. Another element of the hospital analysis included knowing how many ED visits were occurring per thousand patients, which in turn led to the ACO hiring an extra physician to handle urgent care situations, including the expansion of office hours to 10pm. The second category, SNF admissions, involved ensuring that if an admission was clinically justified, the social services and case coordination team called the facility to ensure that the patient received the needed occupational therapy in medially rehab and days later resulting from certain SNF practices had already extending the length of stay. The third category the ACO chose to analyze was specialty visits per thousand patients, assessing the cost effectiveness of those visits. For example, leadership determined that it could be cost-effective for an endocrinologist to provide primary care for a diabetic patient, while a spine surgeon handling the first instance of back pain would not be. This enabled them to reassess when, how, and to whom primary care providers make referrals.

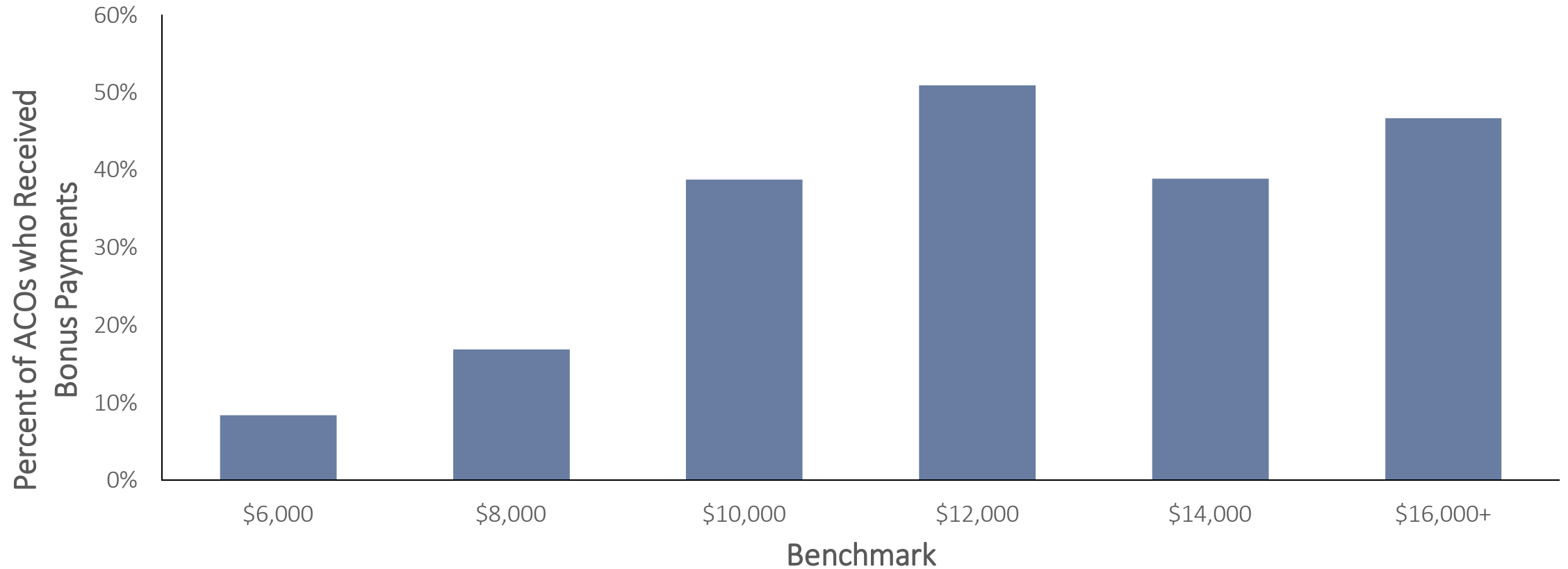
About MyHealth First Network (MyHFN)
 Founded in 2010, Arizona Connected Care was Southern Arizona's first ACO. They are comprised of primary care physicians, specialists, Tucson Medical Center and other health care providers.
 Location: Tucson, AZ
 VIP Ability:
 • Paid MSSP since 2012
 • Commercial arrangements with Cigna and UnitedHealthcare since 2013
 Website: arizonaconnectedcare.org

ACCOUNTABLE CARE LEARNING COLLABORATIVE
 AccountableCareLC.org

www.accountablecareLC.org/CSB

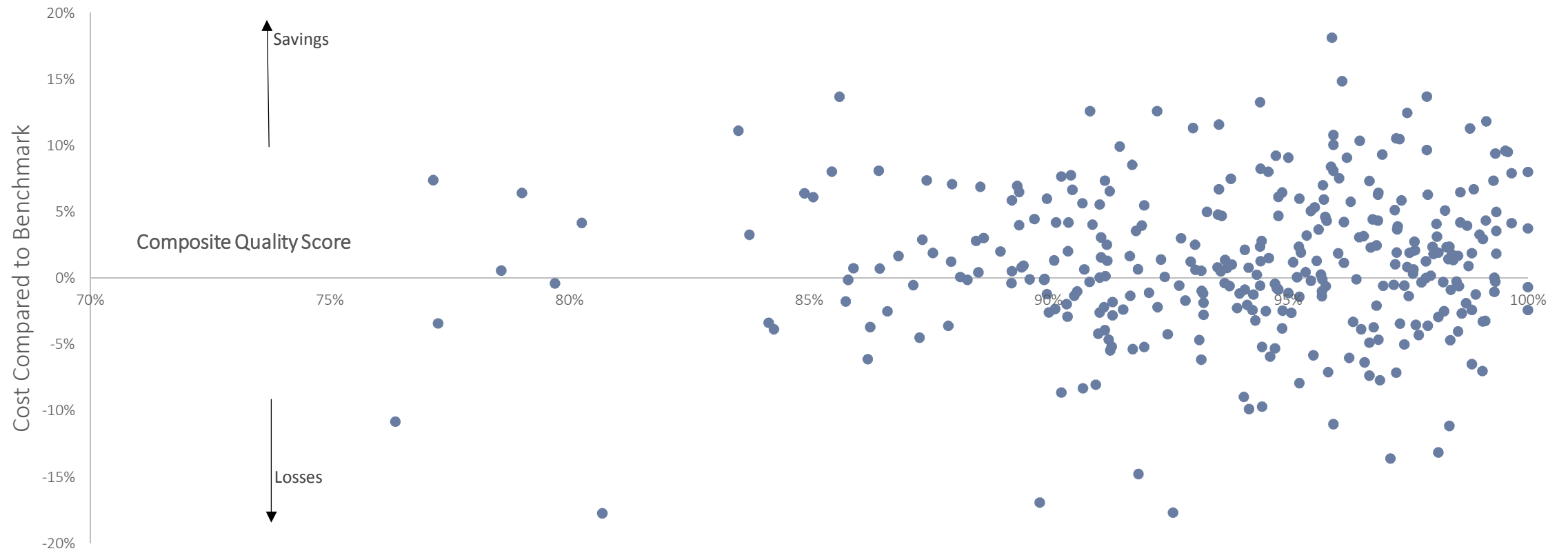
Results by Benchmark

2016 MSSP ACO Results



Quality and Savings

2016 MSSP ACO Quality and Cost Scores



Medicare ACO Program Results 2016

| Program | # Participants | # Participants Who Earned Savings | # Participants Who Owed Losses | Total Aligned Beneficiaries | Total Benchmark Expenditures | Cost per Beneficiary |
|----------|----------------|-----------------------------------|--------------------------------|-----------------------------|------------------------------|----------------------|
| MSSP | 432 | 134 | 4 | 7,884,058 | \$81,376,645,025 | \$10,322 |
| Pioneer | 8 | 6 | 0 | 269,528 | \$3,381,183,973 | \$12,545 |
| Next Gen | 18 | 11 | 7 | 471,734 | \$5,149,126,612 | \$10,915 |
| CEC | 13 | 12 | 0 | 16,085 | \$1,415,517,283 | \$88,001 |
| Total | 471 | 163 | 11 | 8,641,405 | \$91,322,472,893 | \$10,568 |

| Program | Total Benchmark Expenditures Minus Total Expenditures | Gross Savings % | Earned Shared Savings Payments/Owe Losses | Net Savings (Losses) | Net Program Savings % | Net Savings per Beneficiary (Losses) |
|----------|-------------------------------------------------------|-----------------|-------------------------------------------|----------------------|-----------------------|--------------------------------------|
| MSSP | \$651,943,651 | 0.80% | \$691,275,105 | \$(39,331,454) | -0.05% | \$(5) |
| Pioneer | \$68,032,685 | 2.01% | \$37,128,920 | \$30,903,765 | 0.91% | \$115 |
| Next Gen | \$48,299,724 | 0.94% | \$37,973,093 | \$10,326,632 | 0.20% | \$22* |
| CEC | \$75,120,837 | 5.31% | \$51,151,304 | \$23,969,533 | 3.61% | \$1,490 |
| Total | \$843,396,897 | 0.92% | \$817,528,422 | \$25,868,476 | 0.03% | \$3 |

*Incorporating discounts, savings per beneficiary was ~\$134



Why Haven't Value-Based Payment Models Achieved All Their Objectives?

1. Payment models need to be improved
2. Not enough time in the program
3. No clear business case

Todd Allen, MD

INTERMOUNTAIN HEALTHCARE; SALT LAKE CITY, UT

Our Long Journey Around Value

- We were the same as everyone
 - Non-integrated referral-based clinical structure
 - Challenged by managed care
- Three fortunate hires in the early 1980's
 - Allowed quality science, measurement of true cost and data automation to be joined together
- Discovery of Jack Wennberg's work
 - Applied that to the practice level in the form of QUE studies
 - Simple, descriptive process and outcome statistics
 - Minimum variation of 200%
- Discovery of Deming's work, history and techniques

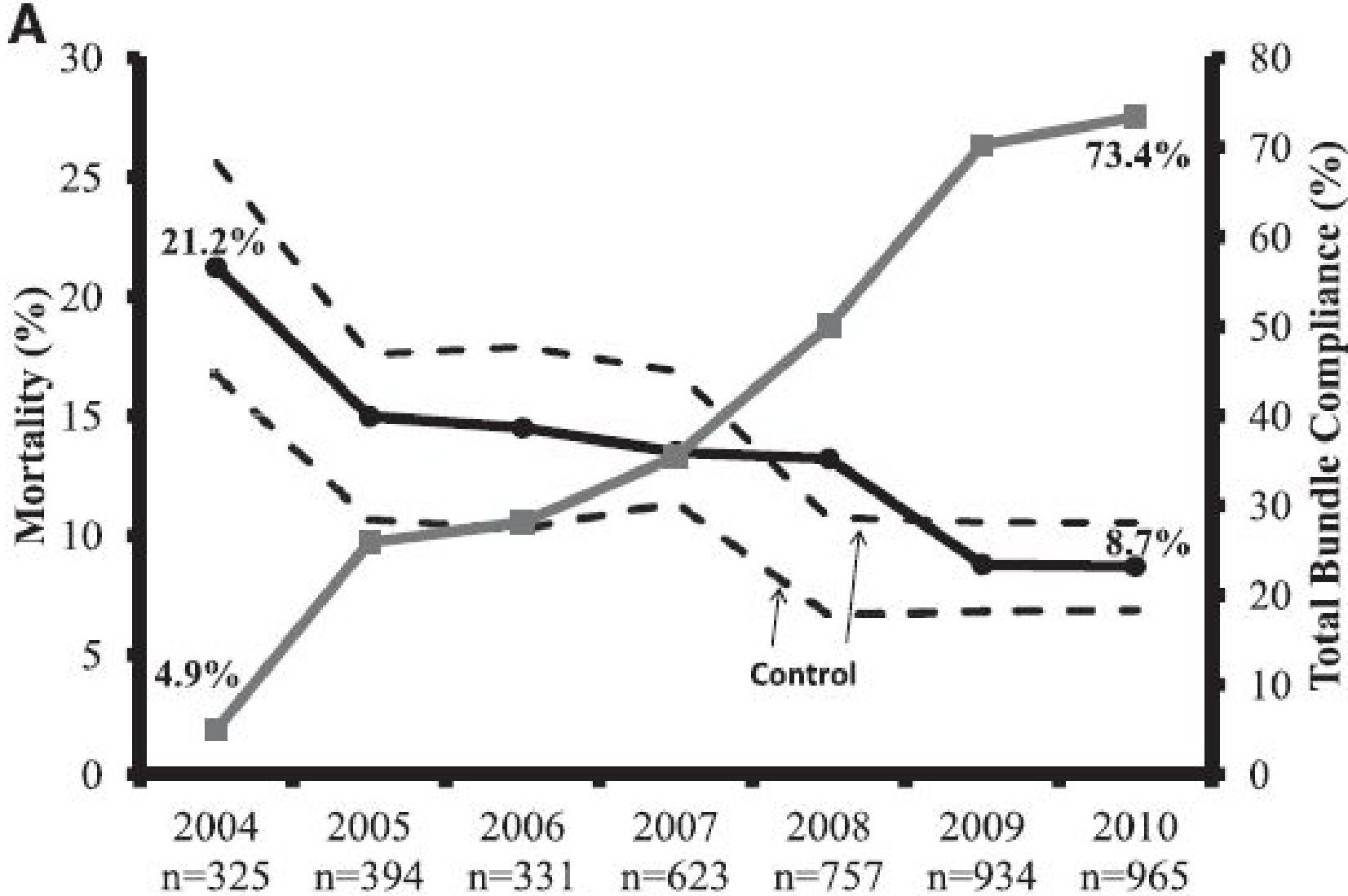
Key Lessons: Lesson 1

- We count our successes in **LIVES**
- There is nothing new here except the idea that “it takes a team” (and perhaps transparent data systems)
- It **SHOULD** have started in medicine

Key Lessons: Lesson 2

- Most often, but not always
- **Better** Care is **Cheaper** Care...
- Our aim is to provide the **best** medical quality at the lowest **necessary** cost.

Mortality and Compliance (All)

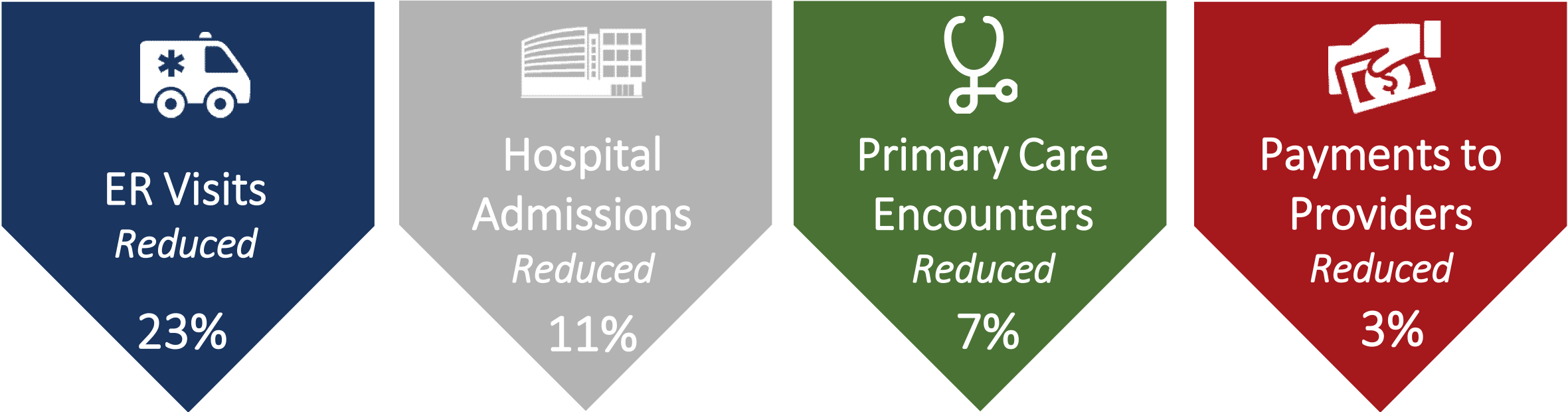


Cost Results By Severity of Sepsis

| Cost variable | Severity of sepsis | Total bundle compliant | | p |
|-------------------------------|--------------------|------------------------|-----------------|----------------|
| | | Non-compliant | Compliant | |
| Adjusted total cost (\$) | Septic shock | 32,498 ± 35,487 | 32,440 ± 35,445 | 0.9767 |
| | Severe sepsis | 28,021 ± 40,301 | 24,589 ± 27,672 | 0.0096* |
| Unadjusted total cost (\$) | Septic shock | 26,868 ± 29,915 | 27,278 ± 29,453 | 0.7604 |
| | Severe sepsis | 21,940 ± 31,737 | 20,858 ± 24,211 | 0.3211 |
| Adjusted variable cost (\$) | Septic shock | 15,304 ± 17,475 | 15,375 ± 17,670 | 0.9426 |
| | Severe sepsis | 13,134 ± 19,892 | 11,468 ± 13,619 | 0.0108* |
| Unadjusted variable cost (\$) | Septic shock | 14,236 ± 16,367 | 14,492 ± 16,551 | 0.7824 |
| | Severe sepsis | 11,871 ± 18,212 | 10,515 ± 12,475 | 0.0234* |

Behavioral Health Clinical Program

Mental Health Integration -- Team-Based Care



Saved \$115 per \$22 investment (per person per year)
for Mental Health Integration

Primary Care Clinical Program: Diabetes Prevention

Treatment Options



Prediabetes 101

2-hour group class



Medical Nutrition Therapy

Individualized nutritional counseling



Weigh to Health

Intensive lifestyle intervention program



Omada Pilot (200 SelectHealth Members)

Guided online evidence-based behavioral counseling

Results



70% more likely

to achieve 5% weight loss in first year



50% less likely

to develop diabetes in first year



400,000 savings

by avoiding or delaying 51 cases of diabetes since 2014

Surgical Services Clinical Program

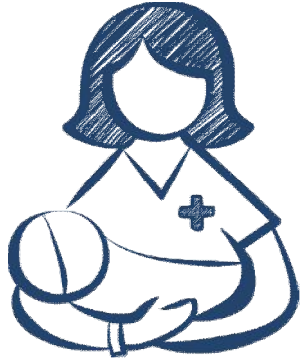
- 225 OR suites
- 50 endoscopy suites
- Approximately 167,000 surgical procedures per year



Innovation through ProComp

- A service to reduce supply and staffing variation in surgical procedures
- Reduces procedure costs and patient length of stay
- Generated \$90 million in savings

Women and Newborns Clinical Program

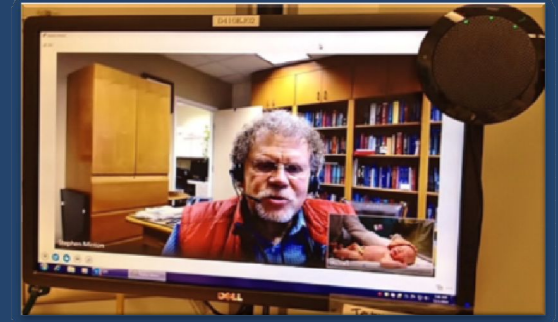


30,885 Births

(58% of Utah births)

3,000 NICU Admissions

INNOVATION TeleHealth Newborn Critical Care Support



390 neonatal consults since 2014,
54 transports avoided
with cost savings of \$980,000

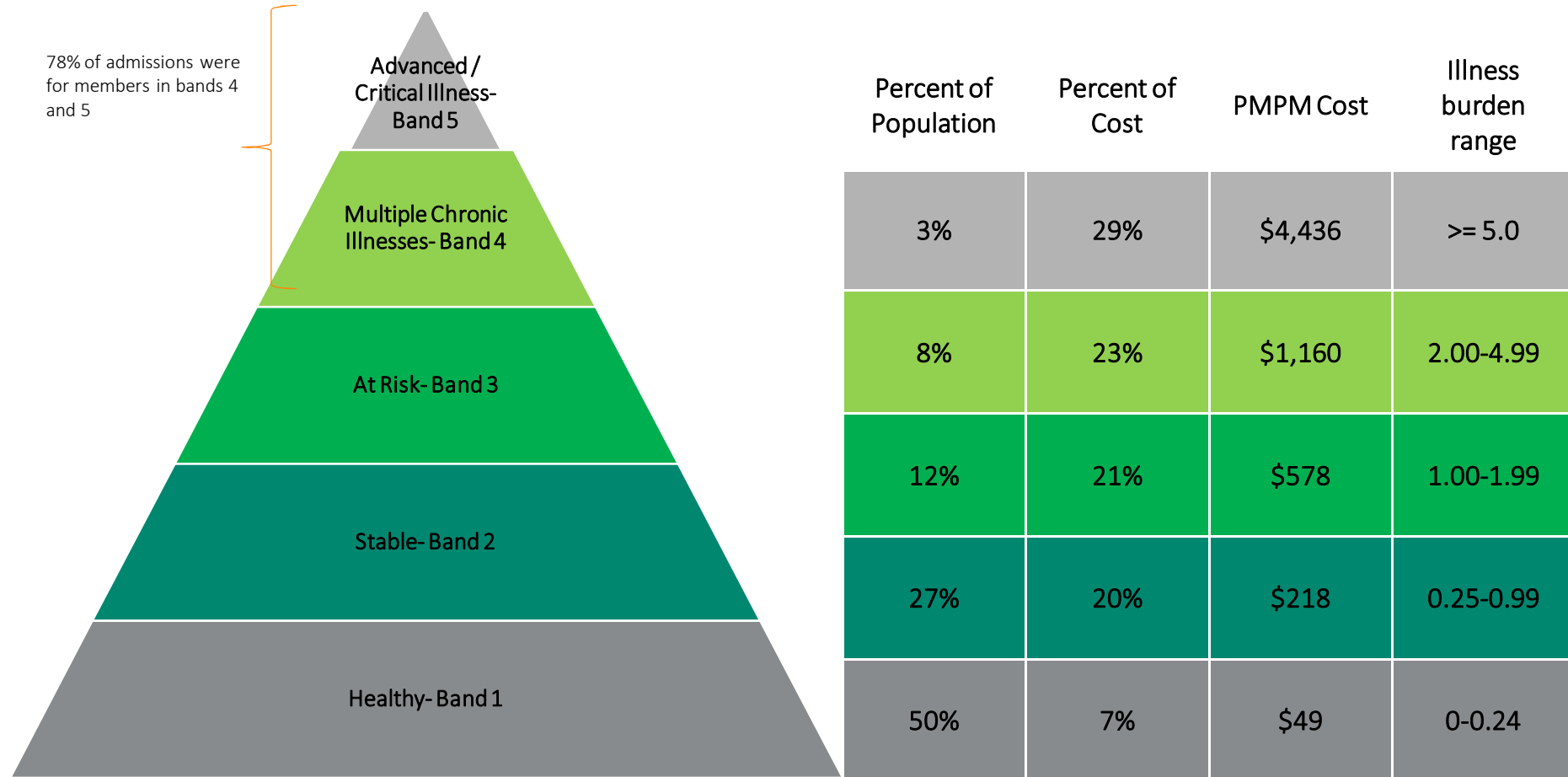
W. Edwards Deming

- Organize **EVERYTHING** around value-added (front line) work processes
- Quality improvement **IS** the science of process management

Ken Cohen, MD

NEW WEST PHYSICIANS; GOLDEN, CO

Move to Risk? The “Why”



Source: CareFirst HealthCare Analytics- 2012 data

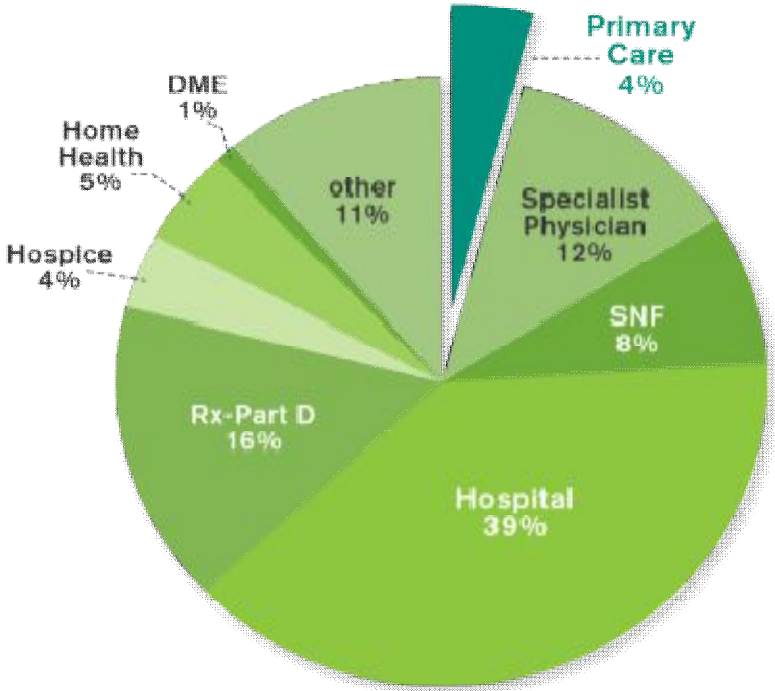
More Care Does Not Equal Better Care!

Wasted care represents 35% of healthcare expenditures and does not improve outcomes or quality of life – the goal of moving into risk is the rigorous elimination of wasted care!



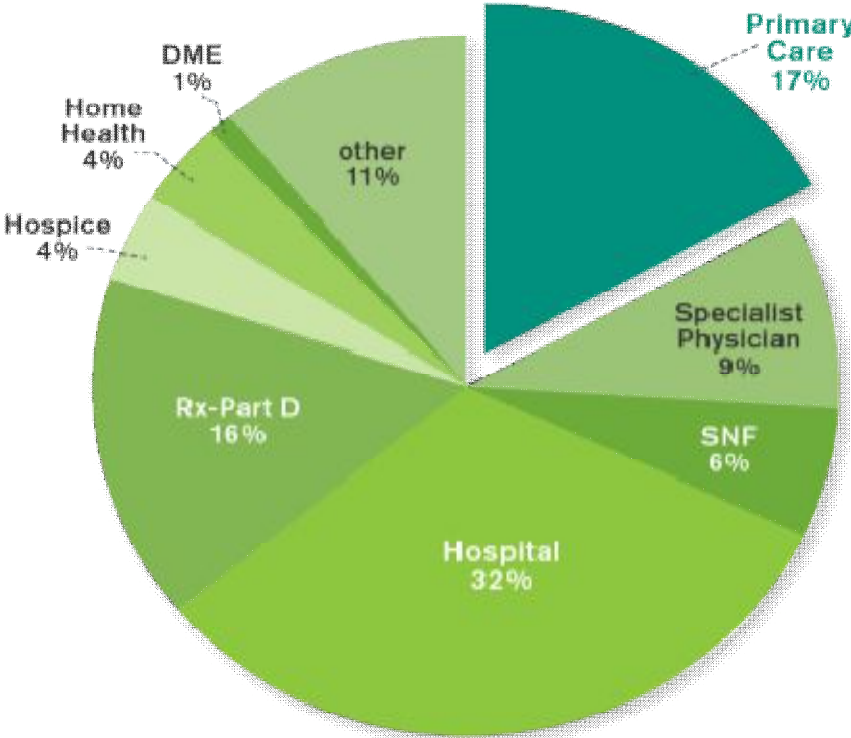
Medicare FFS vs Medicare Advantage Risk Model

Traditional Fee for Service



FFS Revenue \$ 280,000,000

Medicare Advantage Medical Home



MA Revenue \$ 3,800,000,000

*Data from 2011 Medicare Claims

Increased Satisfaction

Physicians

- More time with patients
- More control over patient care
- Improved quality of life
- Improved outcome/performance metrics
- Reduced provider liability
- Potential for incentives

Patients

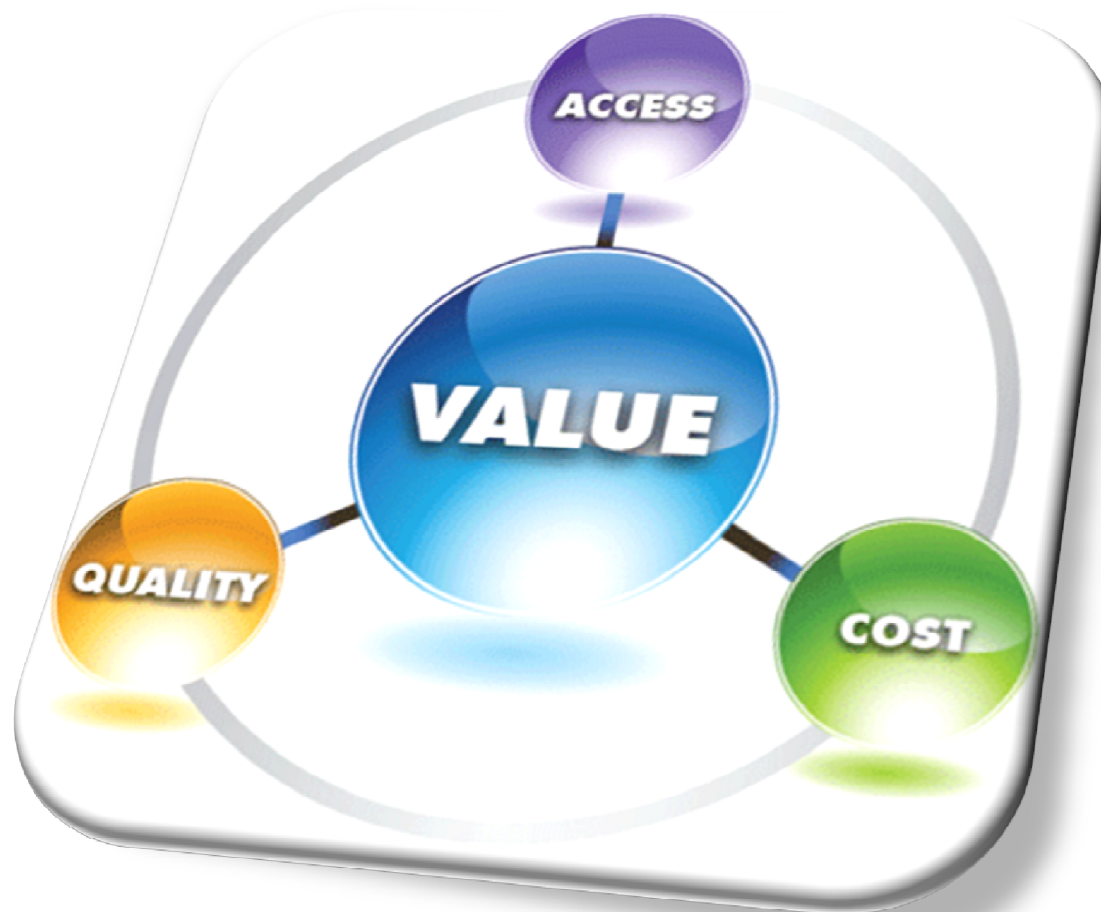
- Better relationship with personal physician
- Improved outcomes and lower mortality!
- Reduced unnecessary care and hospitalization
- Better coordination of care
- Cost savings
- Better health plan benefits

Larry G. Strieff, MD

HILL PHYSICIANS MEDICAL GROUP; SAN RAMONE, CA

Oncology Case Rate (OCR)

Bundle Payment System: **Six-Year Program Results**

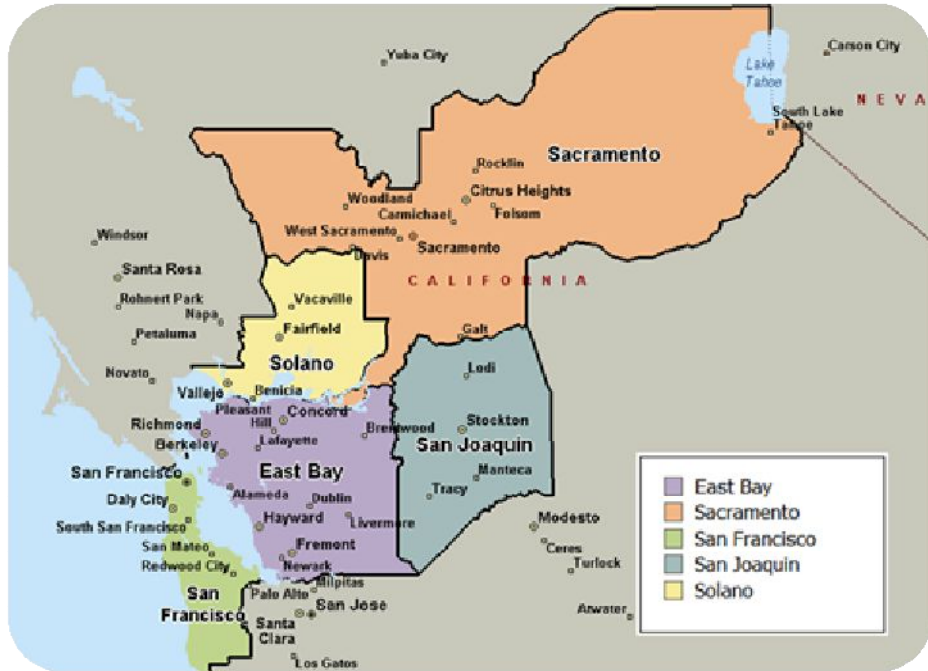


Larry Strieff, MD
Specialty Medical Director
Hematology Oncology Division Chief

Khanh Nguyen, PharmD
Vice President, Pharmacy Services and Population Health

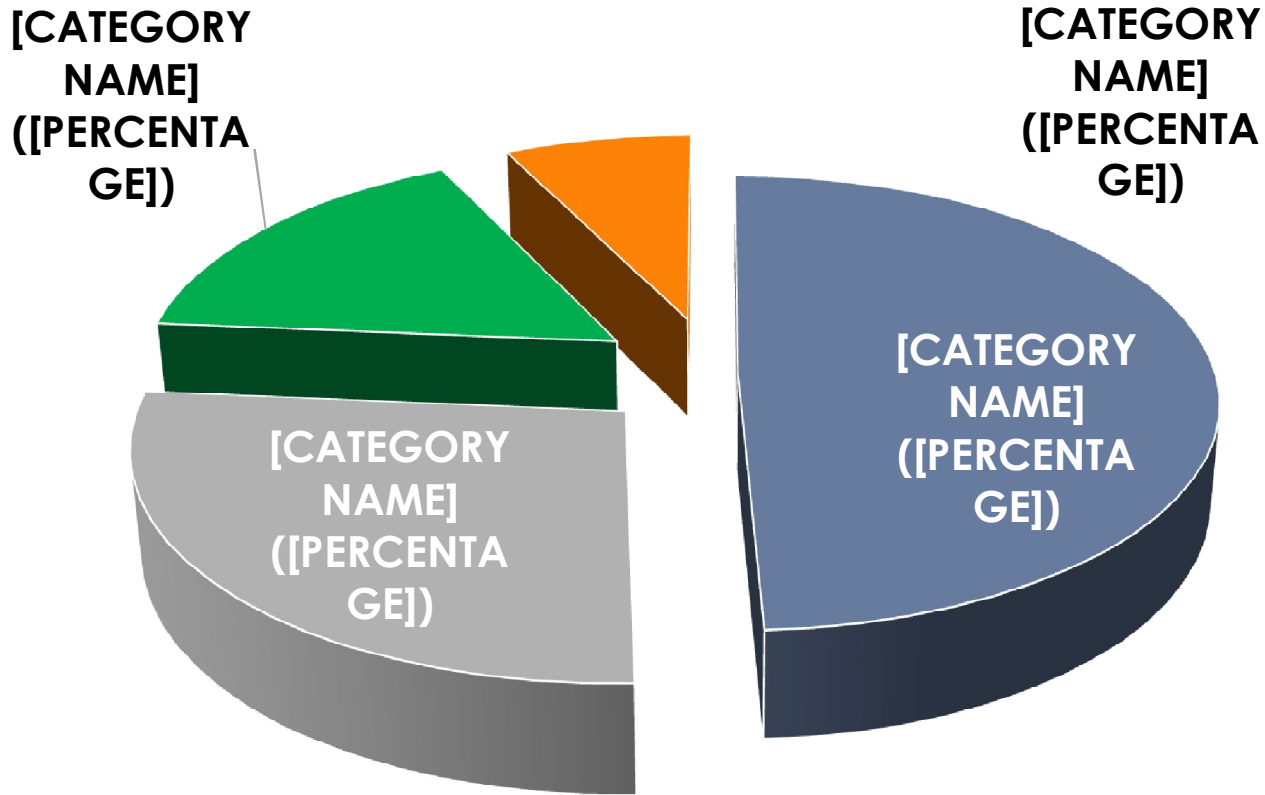
Hill Physicians Medical Group
March 1, 2018

Hill Physicians Medical Group



- ❖ Independent Physician Association founded in 1984
- ❖ Provider network: 4,100 providers and consultants
 - 1,100 Primary Care
 - 3,000 Specialists (**170 Oncologists**)
- ❖ Service the Northern California area
 - 405,000 Members
 - 5 Regions - 10 Counties

California Medical Group Marketplace: 2017 HMO Enrollment



| Medical Group | Est. Members Enrolled |
|------------------------------------------|-----------------------|
| Group Practices, inc. Kaiser | 9.9 million |
| IPAs | 5.4 million |
| Foundations, Community Clinics | 3.3 million |
| University of California & County Groups | 1.5 million |

Mutual Sustainability Through Alignment of Incentives



The Model

Two Linked Modules - Act as Checks & Balances

Case Rate Payments

Cancer dx are grouped

Paid monthly

Providers bear some risk

Stop loss program protects providers

CALCULATED TO BE EQUIVALENT TO 100% FFS



Quality Management Program

Clinical Quality

Patient Experience

Provider Satisfaction

Utilization

OPPORTUNITY FOR ADDITIONAL 10% INCENTIVE

Case Rate portion is best described as a **prospective variable contact cap by cohort**

Quality Management Program (QMP)

| QMP Domains | Description |
|-------------------------------------------------|--------------------------------------------------------------------------------------|
| Clinical Quality | ❖ Subset of 13-24 ASCO QOPI core measures |
| Patient Experience & Physician Satisfaction | ❖ Press Ganey® ❖ Internally developed referring PCP satisfaction survey |
| Utilization | ❖ IP bed days ❖ ED visits ❖ Infusion Center Use ❖ Chemo Initiation |
| OPPORTUNITY FOR ADDITIONAL 10% INCENTIVE | ❖ These are NEW dollars that previously were not available to the oncologists |

Two Key Program Features

Stop Loss

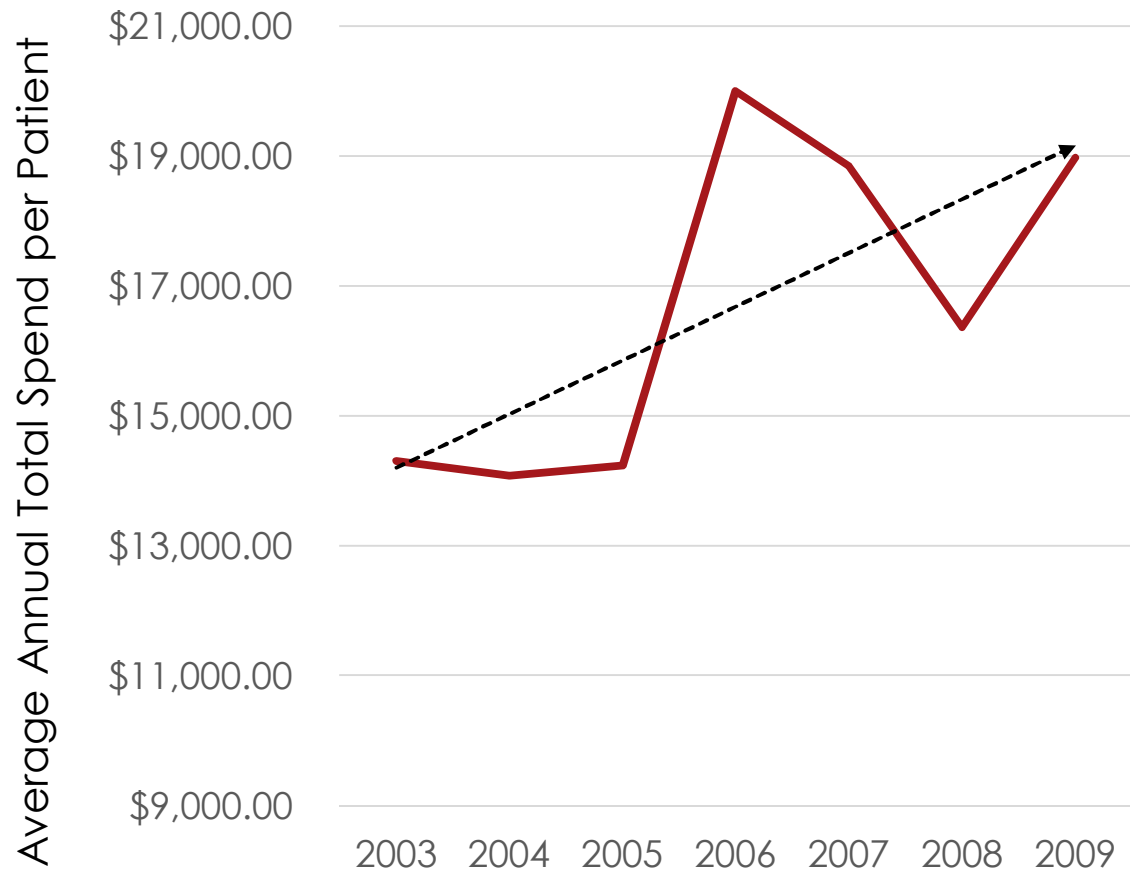
- Protects for new drugs during current case rate year
- No drug exclusions
- No prior authorizations

Annual Recalibration

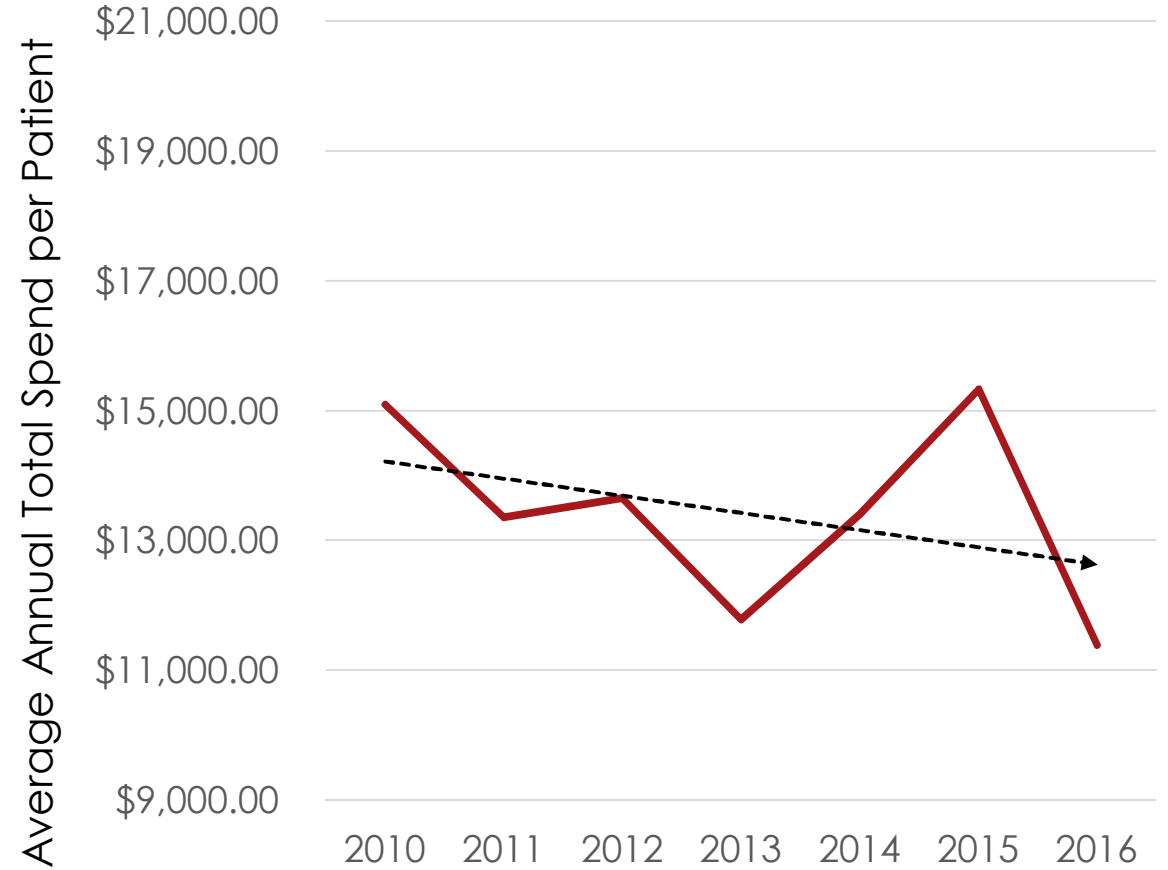
- Provides longer term protection
- Adjusts for use of newer agents

Overall Resource Use: Breast Cancer

Practice Before OCR Implementation

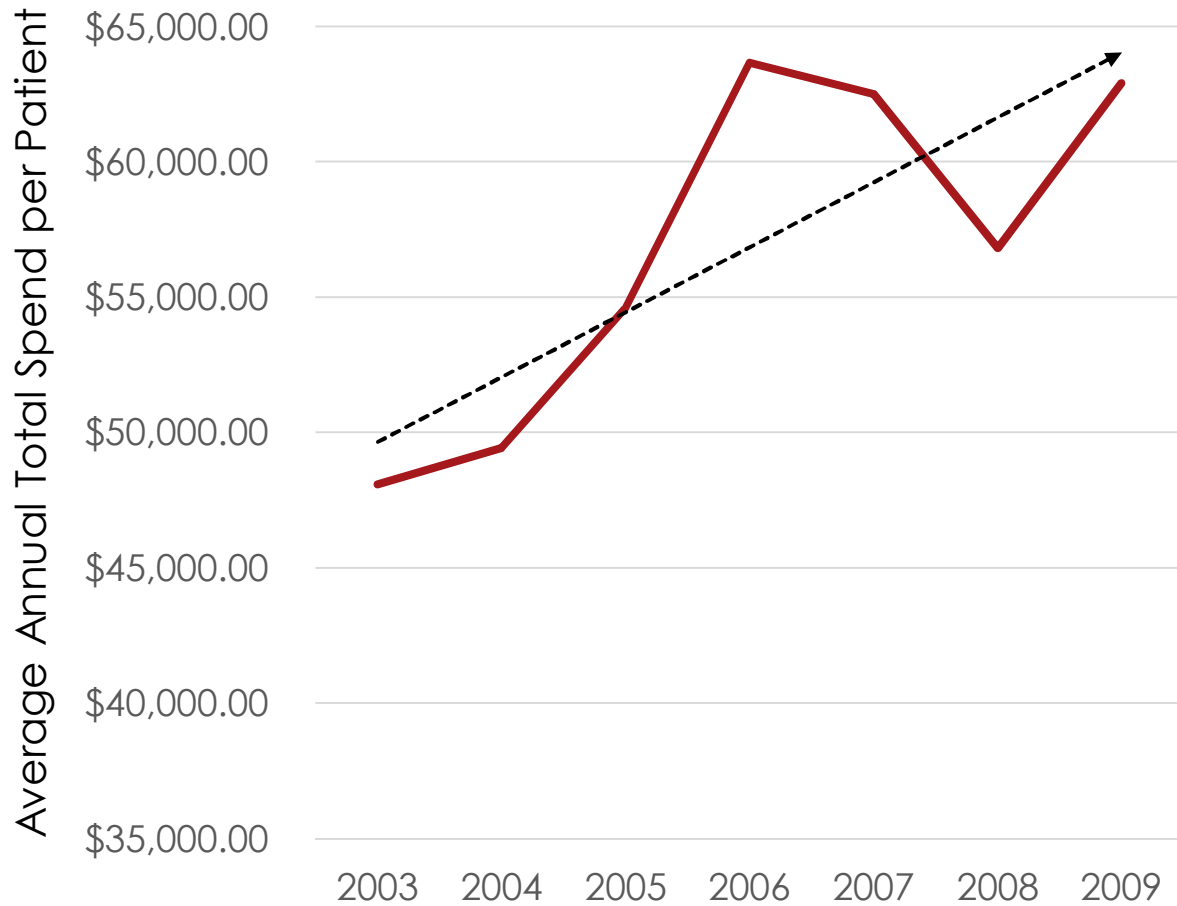


Practice After OCR Implementation

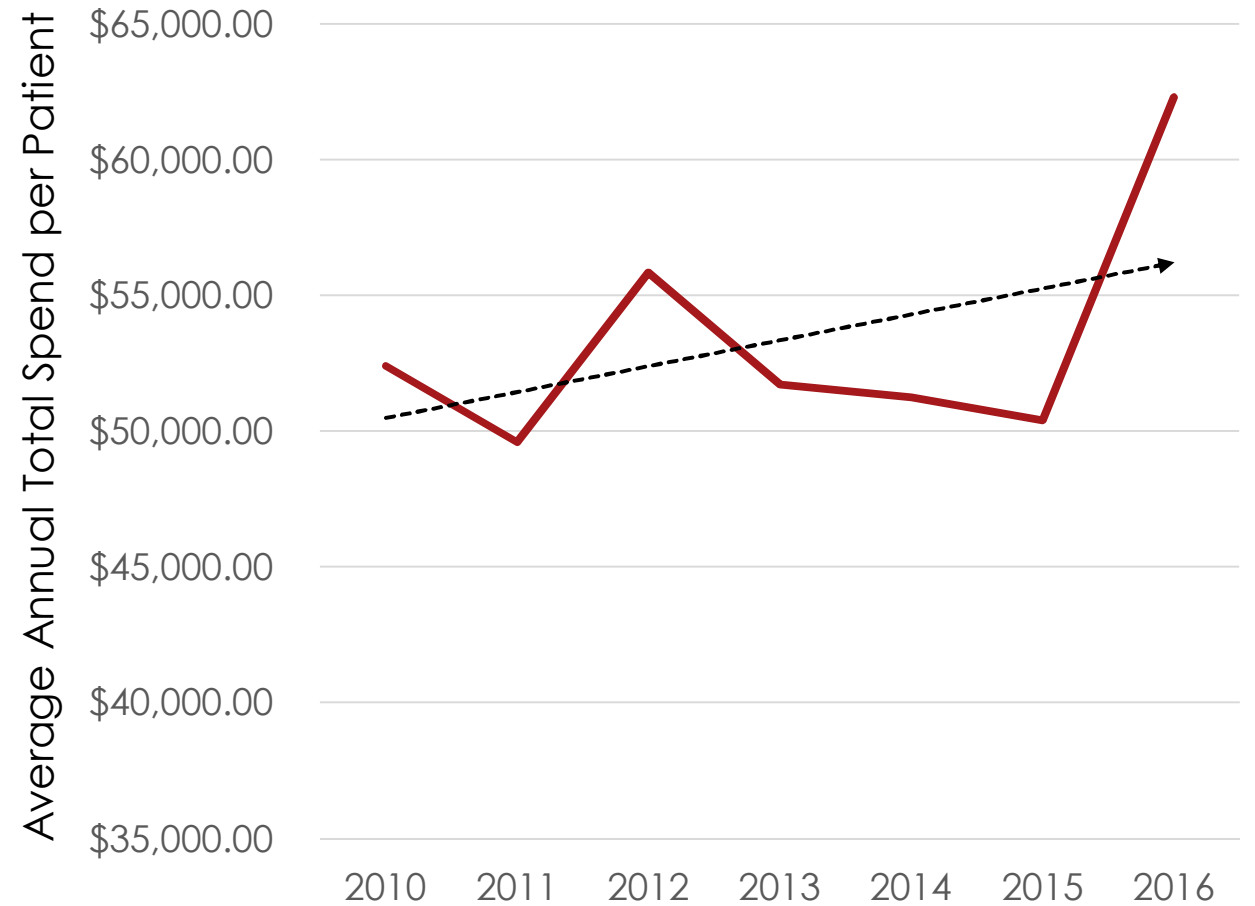


Overall Resource Use: All Cancers

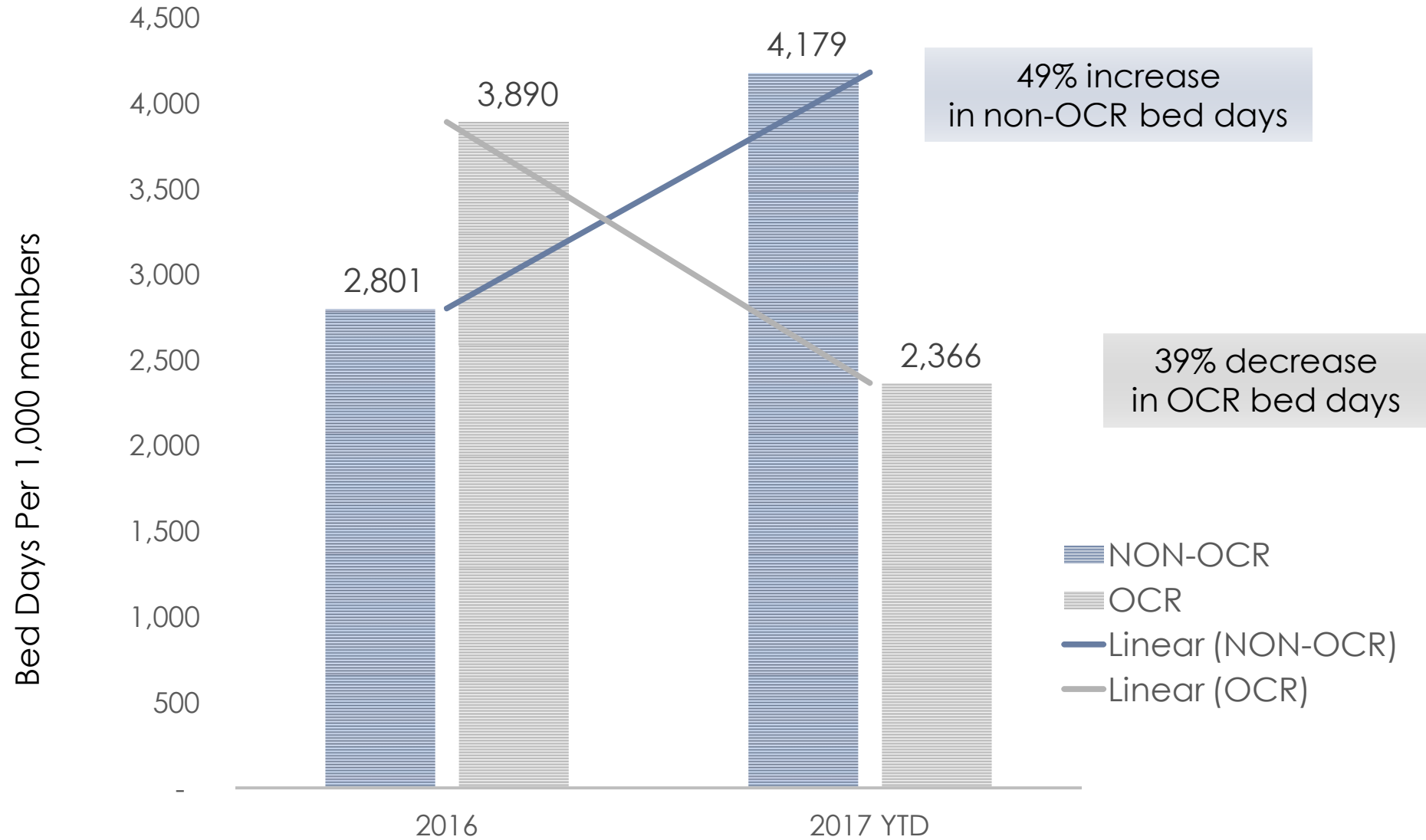
Practice Before OCR Implementation



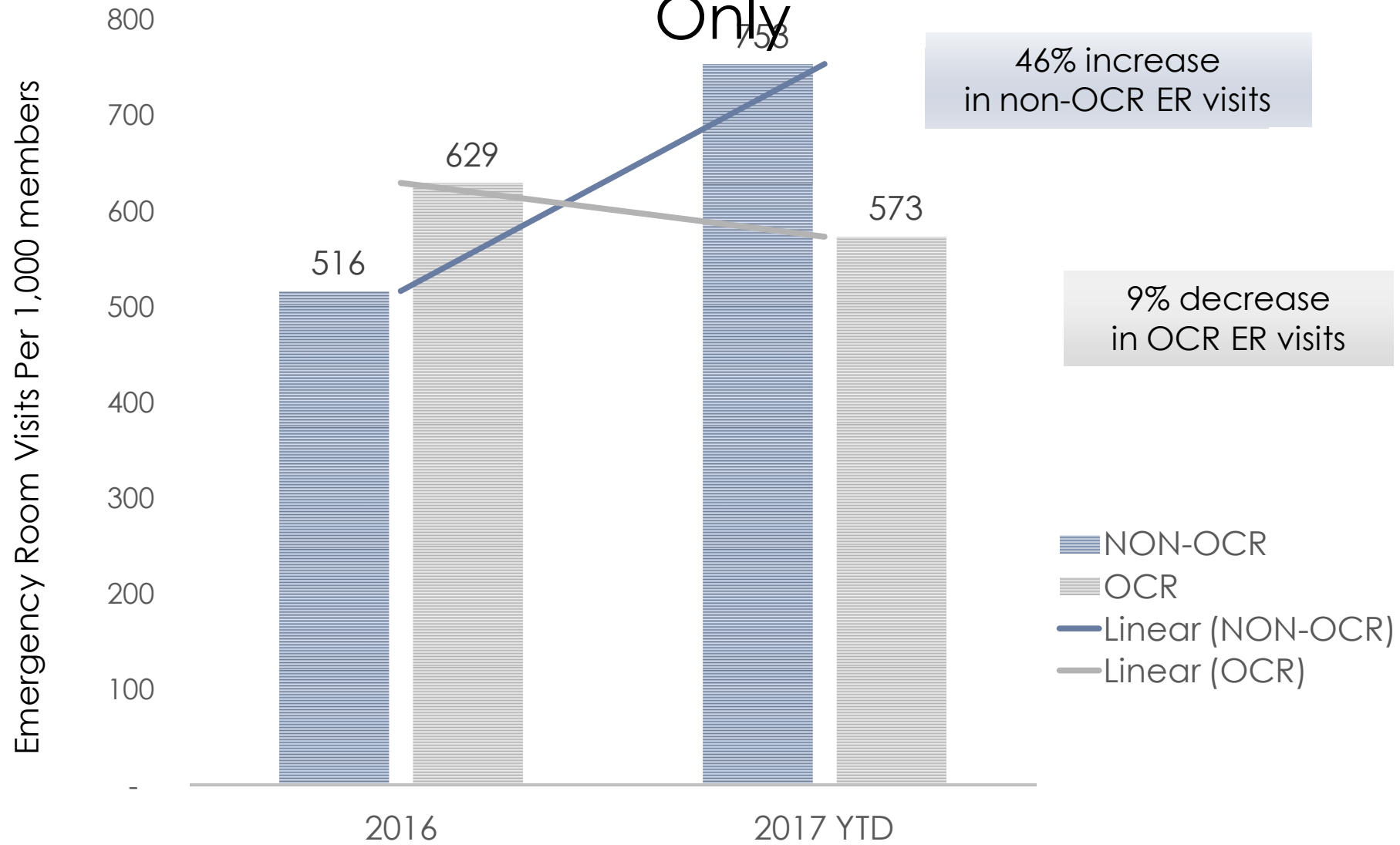
Practice After OCR Implementation



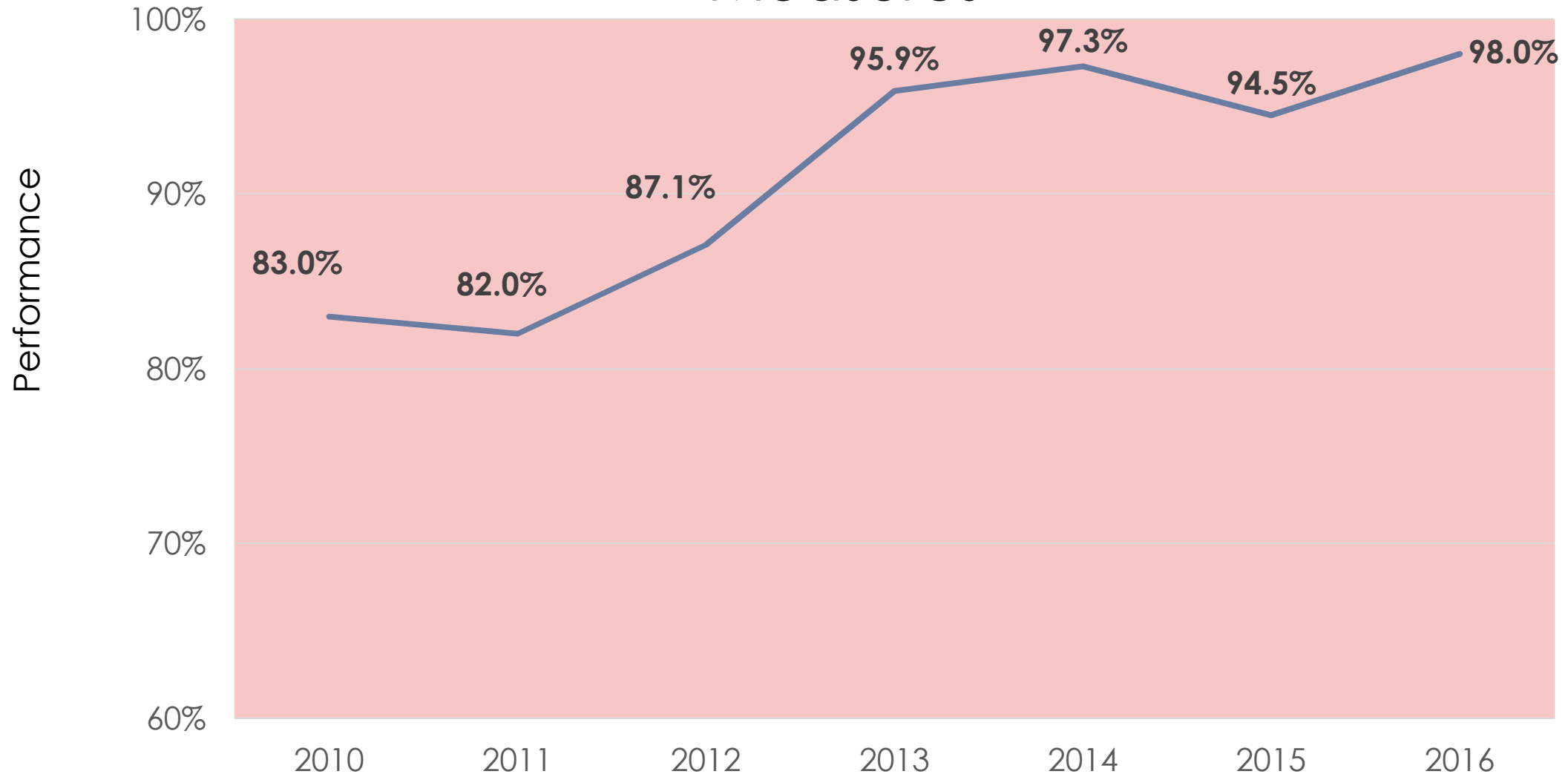
Inpatient Bed Days Per 1,000: Oncology Case Rate-Eligible Patients Only



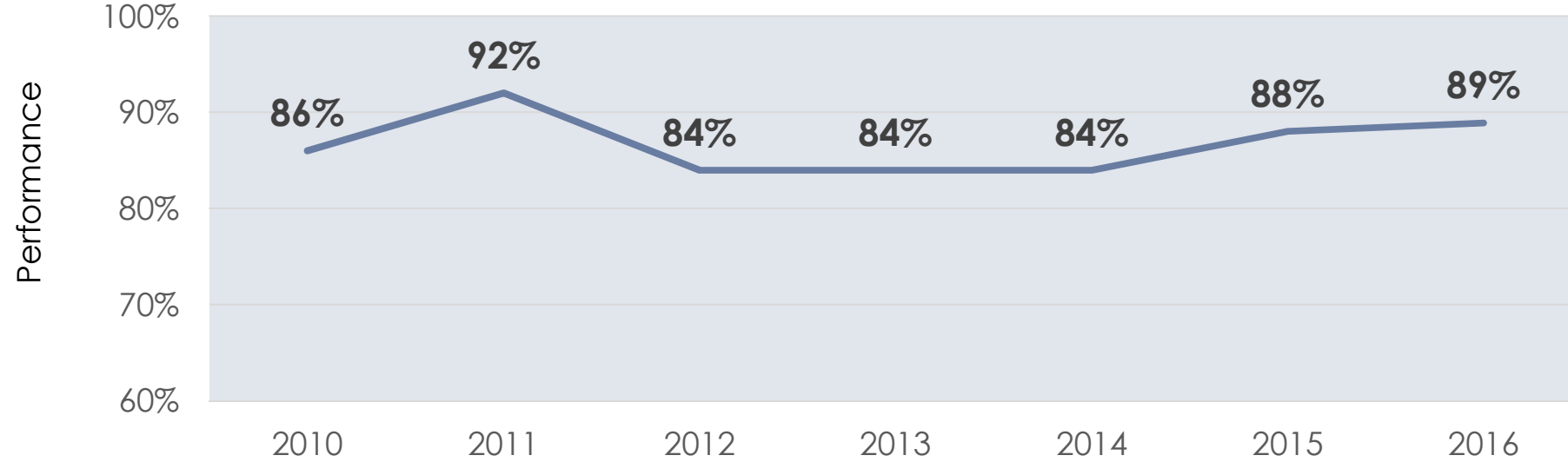
Emergency Room Visits Per 1,000: Oncology Case Rate-Eligible Patients Only



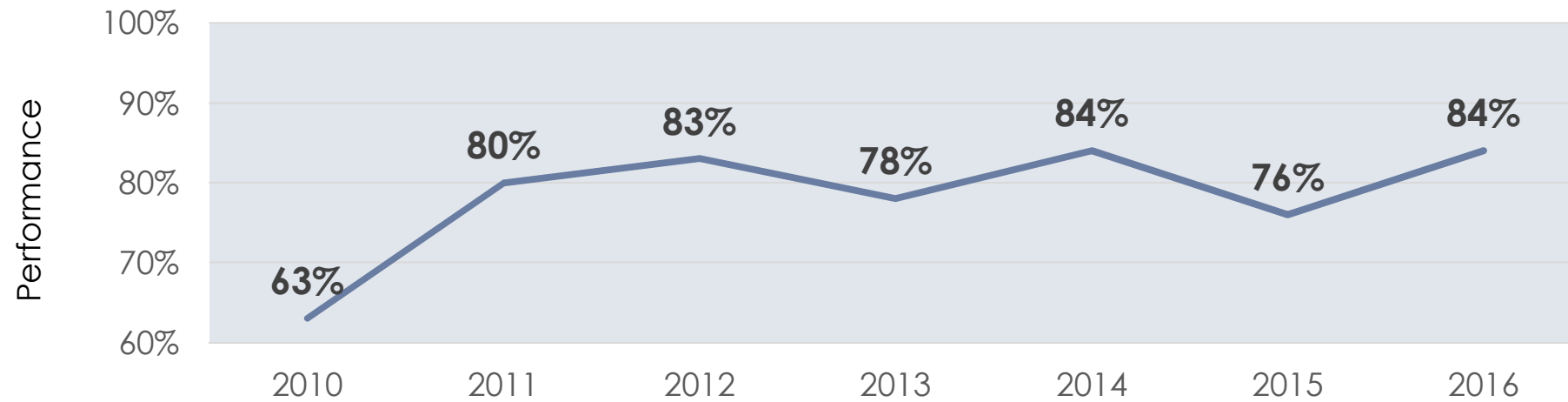
Clinical Quality of Care: Performance on 13-30 ASCO QOPI Measures



Patient Satisfaction



Referring Physician Satisfaction



Oncology Case Rate Program: Observations

Cost Savings

- Decrease in total spend per patient

Better Utilization, Quality

- Decrease in bed days
- Decrease in ER visits
- Increase in ASCO clinical performance

High Satisfaction

- Persistent high levels of patient satisfaction
- Improved referring provider satisfaction