From Bundles to Global Capitation: Aligning Care Models to Payment Models

The 16th Annual Population Health Colloquium
Philadelphia, PA

March 8, 2016
The U.S. Payer Market is Committed to Dramatically Increasing VBC Reimbursement.. Real Risk Still Coming

GOVERNMENT PLEDGES
Health and Human Services (HHS) Announcement

- HHS announced goals for shifting Medicare business to value-based care payment models - 30% payments by the end of 2016 and 50% payments by the end of 2018
- Medicaid Agencies in numerous states expand managed care options for different populations

ALLIANCE PROMISES
Health Care Transformation Task Force (HCTTF)

- Several major providers and payors formed a nonprofit coalition called the HCTTF
- Each member of the HCTTF has committed to shifting 75% of their business to value-based care

COMMERCIAL COMMITMENTS

United Healthcare
- Made $36 billion in value-based care payments in 2014
- Announced plans to increase value-based payments to providers by 20% in 2015 (more than $43 billion)

Blue Cross Blue Shield
- Currently pay $1 out of every $5 of medical claims to value-based programs (~$65 billion)
- Engaged with ~350 local value-based programs nationwide
- Saved ~$500 million as a result of value-based care in 2012

Humana
- 75% percent of their 2 million Medicare Advantage members are cared for through value-based reimbursement models by 2020

Source: Valence Health summary of public statement's and press release from each named organization
…Resulting in Multiple Different Payment Models

- Increased number of ACO’s formed each year:
  - 2011: 64
  - Q1 2012: 174
  - Q1 2013: 447
  - Q1 2014: 621
  - Q1 2015: 744

- Covering over 23M lives:
  - 2011: 2.1M
  - 2012: 5.6M
  - 2013: 14.6M
  - 2014: 19.2M
  - 2015: 23.5M

- ~2000+ Providers in CMS Bundled Payments Pilots

- PSHP’s taking many flavors:
  - Medicaid/MA/Commercial: 28
  - MA/Commercial: 13
  - Medicaid Commercial: 15
  - Commercial Only: 11
  - MA Only: 11
  - Medicaid Only: 7
  - Medicaid/MA: 17

Source: Centers for Medicare & Medicaid Services
Yet, Only One-Third of Providers Are Currently Taking Risk

What types of arrangements or models does your hospital or your owned medical groups currently have in place? In two years?

<table>
<thead>
<tr>
<th>Model Description</th>
<th>Medicare</th>
<th>Medicaid</th>
<th>Commercial</th>
<th>DTE</th>
<th>Own ins license PSHP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pioneer ACO</td>
<td>64%</td>
<td>33%</td>
<td>60%</td>
<td>56%</td>
<td>32%</td>
</tr>
<tr>
<td>MSSP</td>
<td>32%</td>
<td>37%</td>
<td>44%</td>
<td>44%</td>
<td>15%</td>
</tr>
<tr>
<td>Bundled Pymnts</td>
<td>50%</td>
<td>50%</td>
<td>32%</td>
<td>25%</td>
<td>15%</td>
</tr>
<tr>
<td>Medicaid contract</td>
<td></td>
<td>98%</td>
<td>12%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bundles</td>
<td>44%</td>
<td></td>
<td>32%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ins prod - ins admin</td>
<td>62%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ins prod - Shared risk</td>
<td>69%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bundled Pymnts</td>
<td>73%</td>
<td>60%</td>
<td>18%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Direct contract</td>
<td></td>
<td>54%</td>
<td>28%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Own ins license PSHP</td>
<td></td>
<td></td>
<td>15%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The level of risk for the 1/3 today is low, but growing

Source: AHA 2015 Data Review
Why?

• Once you have seen one health system or provider organization, you have (really) only seen one…

• There are incredible differences within these organizations in the following areas:
  • Resources
  • Competitive factors
  • Risk management experience
  • Market payor characteristics
  • “Attitude”

• And…
  • Optimization of CARE DELIVERY
Moving Providers To More Risk

How Can Clinical Care Models Be Optimized to Encourage?

Incentives → Population Health Mgmt → Payment Model → Incentives

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As the Shift Plays Out, Providers Will Continue To Exist Along a Spectrum of Models
8 Hospital, 2500 physician CIN
Two provider town
Valence provided CIN technology, Care Manager technology, Advisory Services

Methodist Le Bonheur Healthcare

4 Hospital system
MSSP participant
Competitive urban/suburban market
Valence provides Advisory Services

Care New England

Dominant pediatric institution in multi-state region
Fully delegated risk via sub-capitated Medicaid
Valence provides Care Management and Interim Executive

Cincinnati Children’s Hospital Medical Center

300 Bed, Single Hospital IDN in Dalton, GA (rural setting)
50% Owner commercial health plan with local IPA
Valence provides technology, Health Plan Services

Hamilton Health Care System

Single hospital system, semi-rural setting
100+ physician CIN
Recently approved MSSP
Valence provides technology and Health Plan Services

Centegra HealthSystem

4 Hospital IDN
500 Physician CIN, Delegated Medicaid and Commercial Risk
Valence provides technology, Advisory Services, Interim Executive, Health Plan Services

Ingalls

Standalone pediatric hospital, Corpus Christi, TX
130,000 live Medicaid Plan, $300+ million
Valence provides technology, Advisory Services, Health Plan Services

NorthShore University Health System

3 hospitals, 75+ practices, 500 physician CIN
Valence provides CIN technology

3 hospitals, 75+ practices, 500 physician CIN
Valence provides CIN technology

4 Hospital, 2500 physician CIN
Two provider town
Valence provided CIN technology, Care Manager technology, Advisory Services
Moving To The Right

Structure

Ambulatory

Inpatient & Interventional

Care Continuum
Moving To The Right

Structure
- Primary care?
- Populations? Market? Payors?
- Compensation system?
- Provider structure governance?
- What’s my footprint?
- What types of facilities?
- Current risk programs?

Ambulatory
- Platform tech (EHR, Analytics…)
- Disease or efficiency mgmt tools?
- Do I know how to care manage?
- PCMH or similar?
- Care management personnel?
- How are my quality outcomes?

Inpatient & Interventional
- Specialists practicing EBM?
- Have I eliminated variability?
- Can I manage LOS?
- Am I managing discharge and F/U?
- How are my quality outcomes?
- Can I manage patient satisfaction?
- Supply chain optimized?
- Facility, infrastxr, maint costs?

Care Continuum
- What influence or control do I have over...
  - Home health
  - LTACH
  - Rehab
  - SNF
  - Complex institutional care
  - Elderly care
  - Community (church, school, other)
Up Front Statements

- Employing dramatically different types of care management based on payment model has not served us well.

- There are a number of basic competencies that are needed no matter the payment model.

- As you move from isolated pay-for-performance arrangements to full risk, there is a need to be working more effectively in “all four boxes”
Basic Competencies Every Payment Model Needs

1. Effectively Engaging Patients
   • Effective “traditional” (top of the triangle) care management
   • Reaching “deeper into the triangle”
   • Primary care is the coin of the realm
   • New technologies MUST be leveraged

2. Effectively Engaging Clinicians
   • The Last mile is the first mile
   • Analytics and reporting approaches – “providers are the effector arm”

3. Effectively Targeting Both Condition Specific And Operational Challenges providers and patients face

Asthma
COPD
CHF
Diabetes
Back Pain
Obesity
Behavioral
Pregnancy
Etc.

ER Use
Clinic Visits
Attribution
Scheduling
EBM
Triage
Etc.
Effectively Engaging Patients
Not Just Those At The Top Of The Pyramid

- **THE TOP 5%**
  - Most severe
  - Easily identified
  - Most providers with programs

- **WALKING WOUNDED**
  - Less severe, known condition diagnosis
  - Easily identified
  - Many in management programs

- **UNDER THE RADAR**
  - Have condition
  - No diagnosis, unknown diagnosis
  - Managed episodically, acute care and triage

- **ON THE LEDGE**
  - At risk in the next ~5 years of developing condition
  - Early indicators identifiable

- **HEALTHY**

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Effectively Engaging Patients
Not Just “Putting Out Fires”

Advanced Care Management
• Prevent patients from becoming expensive
• Prevent operational challenges
• *Shutting down the catapult*

Conventional Care Management
• Case managing the most expensive patients
• Identifying operational challenges
• *Putting out fires*
Effectively Engaging Clinicians
Comprehensive Analytics Are No Longer Optional

<table>
<thead>
<tr>
<th>Clinical Quality (Vision)</th>
<th>Analysis and reporting (vQuest)</th>
<th>Care Management (vCare)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Clinical integration</td>
<td>• Analyze medical costs and</td>
<td>• Workflow solution for</td>
</tr>
<tr>
<td>− Aggregate data</td>
<td>trends</td>
<td>medical management</td>
</tr>
<tr>
<td>− Physician attribution</td>
<td>• Stratify and prioritize</td>
<td>− Utilization Management</td>
</tr>
<tr>
<td>• Patient care</td>
<td>patients</td>
<td>− Case Management</td>
</tr>
<tr>
<td>− Risk stratify</td>
<td>• Predictive modeling</td>
<td>− Disease management</td>
</tr>
<tr>
<td>populations</td>
<td>• Tracks medical expense</td>
<td>• Designed to support</td>
</tr>
<tr>
<td>− Identify care</td>
<td>across major categories</td>
<td>URAC and NCQA standards</td>
</tr>
<tr>
<td>gaps</td>
<td>• Measure provider performance</td>
<td>• Drives patient</td>
</tr>
<tr>
<td>− Build registries</td>
<td>on cost and utilization</td>
<td>engagement</td>
</tr>
<tr>
<td>• Provider performance</td>
<td>• Supports delegated Risk and</td>
<td>• Analytics align with</td>
</tr>
<tr>
<td>− Benchmark</td>
<td>health plans</td>
<td>Vision and vQuest</td>
</tr>
<tr>
<td>performance measures</td>
<td></td>
<td>• Embedded care</td>
</tr>
<tr>
<td>• Campaign outreach</td>
<td></td>
<td>guidelines</td>
</tr>
</tbody>
</table>

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Effectively Engaging Clinicians
Without Effective Governance and Reporting, Little Action
## Pediatric Medicaid Targets
### Condition and Utilization

<table>
<thead>
<tr>
<th>Driver</th>
<th>Cost PMPM ($)</th>
<th>Goal / Solution Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Office Visits</td>
<td>20.32</td>
<td>Virtual or telemed care</td>
</tr>
<tr>
<td>Outpatient ER</td>
<td>15.07</td>
<td>Triage tech – app level of care</td>
</tr>
<tr>
<td>Single Live Born</td>
<td>10.09</td>
<td>Shared Decision Making, Prevention undesired preg</td>
</tr>
<tr>
<td>Acute Inpatient Surgical</td>
<td>7.63</td>
<td>Encourage outpatient surgery, Education</td>
</tr>
<tr>
<td>Health Supervision Child</td>
<td>5.16</td>
<td>Virtual or telemed care</td>
</tr>
<tr>
<td>Asthma</td>
<td>1.45</td>
<td>Disease Management Technologies</td>
</tr>
<tr>
<td>Acute URI</td>
<td>1.40</td>
<td>&quot; &quot; &quot;</td>
</tr>
<tr>
<td>Vaccination</td>
<td>0.38</td>
<td>Vaccinate home / convenient care</td>
</tr>
<tr>
<td>Drug Costs</td>
<td>?</td>
<td>Equivalencies, generics, incentives</td>
</tr>
<tr>
<td>Nutritional Deficits (A)</td>
<td>?</td>
<td>Dz Management Technologie</td>
</tr>
<tr>
<td>Trauma (A)</td>
<td>?</td>
<td>Education, resources</td>
</tr>
<tr>
<td>Care Gaps (A)</td>
<td>?</td>
<td>Vision, Emmi, CVS</td>
</tr>
</tbody>
</table>

A = Aggravating or proximate cause
## Adult Medicaid Targets
### Condition and Utilization

<table>
<thead>
<tr>
<th>Driver</th>
<th>Cost PMPM ($)</th>
<th>Goal/Solution Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Maternity</td>
<td>62.43</td>
<td>Shared Decision Making, Prevention undesired preg</td>
</tr>
<tr>
<td>Outpatient ER</td>
<td>28.08</td>
<td>Virtual or teledemed care, Triage tech – app level care</td>
</tr>
<tr>
<td>Normal Pregnancy</td>
<td>24.01</td>
<td>Shared Decision Marking, Prevention undesired preg</td>
</tr>
<tr>
<td>Office Visits</td>
<td>21.77</td>
<td>Virtual or teledemed care, Triage – app level care</td>
</tr>
<tr>
<td>Inpt Surgery - Maternity</td>
<td>19.76</td>
<td>Shared Decision Making, Prevention undesired preg</td>
</tr>
<tr>
<td>High Risk Pregnancy</td>
<td>9.86</td>
<td>Shared Decision Making, Prevention undesired preg</td>
</tr>
<tr>
<td>HTN</td>
<td>9.58</td>
<td>Dz Management technologies</td>
</tr>
<tr>
<td>Sickle Cell</td>
<td>8.43</td>
<td>Augmented case management</td>
</tr>
<tr>
<td>Drug Costs</td>
<td>?</td>
<td>Equivalencies, generics, incentives, formulary</td>
</tr>
<tr>
<td>Behavioral Health (A)</td>
<td>?</td>
<td>Less intensive / virtual platforms</td>
</tr>
<tr>
<td>Renal Failure / Dialysis</td>
<td>?</td>
<td>Shared Decision Making (perit dialysis), Case finding</td>
</tr>
<tr>
<td>Smoking (A)</td>
<td>?</td>
<td>Cessation Adjuncts</td>
</tr>
<tr>
<td>Alcoholism (A)</td>
<td>?</td>
<td>Moderation Adjuncts? Case finding?</td>
</tr>
<tr>
<td>Care Gaps (A)</td>
<td>?</td>
<td>Vision, Emmi, CVS</td>
</tr>
</tbody>
</table>

_A = Aggravating or proximate cause_
### Medicare Targets

**Condition and Utilization (Medicare Cost Report, 2013)**

<table>
<thead>
<tr>
<th>Driver</th>
<th>APC/DRG</th>
<th>HCPCS</th>
<th>Goal / Solution Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinic (I, II)</td>
<td>$1.1B</td>
<td>$11B</td>
<td>Virtual care, triage platforms – app level care</td>
</tr>
<tr>
<td>Inpatient physician care</td>
<td></td>
<td>$7.0B</td>
<td>EBM, Reduce Variability, Clinical pathways, shared decision making</td>
</tr>
<tr>
<td>Joint replacement</td>
<td>$5.0B</td>
<td></td>
<td>Shared decision making, EBM</td>
</tr>
<tr>
<td>Heart Failure (cc and mcc)</td>
<td>$3.5B</td>
<td></td>
<td>Dz management technologies</td>
</tr>
<tr>
<td>Nerve Inj / Spinal Fusion</td>
<td>$2.0B</td>
<td></td>
<td>Shared decision making, EBM</td>
</tr>
<tr>
<td>Ambulance Transport</td>
<td></td>
<td>$2.0</td>
<td>Tiered transport options</td>
</tr>
<tr>
<td>Cataract Surgery</td>
<td></td>
<td>$1.7B</td>
<td>EBM</td>
</tr>
<tr>
<td>PCI</td>
<td>$1.2B</td>
<td></td>
<td>Shared decision making EBM</td>
</tr>
<tr>
<td>COPD</td>
<td>$1.1B</td>
<td></td>
<td>Case finding, Dz management technologies</td>
</tr>
<tr>
<td>Renal Failure</td>
<td>$1.1B</td>
<td></td>
<td>Case finding, shared decision making (peritoneal dialysis)</td>
</tr>
<tr>
<td>Echo / Cardiac Imaging</td>
<td>$1.1B</td>
<td>$1.0B</td>
<td>EBM</td>
</tr>
<tr>
<td>Medical Eye Exam</td>
<td></td>
<td>$1.0B</td>
<td>EBM</td>
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<tr>
<td>Inpatient Critical Care</td>
<td></td>
<td>$900M</td>
<td>EBM</td>
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<tr>
<td>Therapeutic Exercise (Rehab)</td>
<td></td>
<td>$900M</td>
<td>Virtual rehab platforms</td>
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<tr>
<td>Hip and Femur (replace)</td>
<td>$900M</td>
<td></td>
<td>Shared decision making</td>
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<tr>
<td>ER (III, IV)</td>
<td>$600M</td>
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<td>Triage platforms – app level of care</td>
</tr>
<tr>
<td>MRI</td>
<td>$423M</td>
<td></td>
<td>EBM</td>
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<tr>
<td>Sleep</td>
<td>$267M</td>
<td></td>
<td>Mobiel sleep study technologies</td>
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<tr>
<td>Medication</td>
<td></td>
<td></td>
<td>Equivalencies, generics, incentives, formulary</td>
</tr>
<tr>
<td>Behavioral Health (A)</td>
<td></td>
<td></td>
<td>Less intensive / virtual platforms</td>
</tr>
<tr>
<td>Care Gaps (A)</td>
<td></td>
<td></td>
<td>Vision plus partners</td>
</tr>
<tr>
<td>End-Of-Life</td>
<td></td>
<td>Big</td>
<td>Shared decision-making, intense education, hospice services</td>
</tr>
</tbody>
</table>

A = Aggravating or proximate cause
Working in all Four Boxes

P 4 P  |  PCMH  | CLINICAL INTEGRATION  | BUNDLE PAYMT  | SHARED SAVINGS  | SHARED RISK  | CAPITATED / FULL RISK  | HEALTH PLANS

Ambulatory

Structure

Care Continuum

Inpatient & Interventional
• As you go from Left to Right…
  • More “organized” primary care structures
  • More formal provider governance
  • Compensation models that increasingly reward VBC activities
  • More lives / More market share
  • Willingness or ability to “take on” commercial payors
  • More comprehensive clinical care offerings – inpatient and ambulatory
  • Willingness to regionalize expensive interventional services
• **As you go from Left to Right...**
  • Optimized use of the EHR
  • Analytics increasingly important
  • PCMH or similar structures needed
  • Case and Disease Management capabilities needed
  • Quality and clinical outcomes measurement, actionable reporting
  • Patient engagement
  • The use of digital and other tools
    • Wellness
    • Engagement
    • Case Mgmt
    • Disease Mgmt
    • Triage
Interventional and Inpatient Care

- As you go from Left to Right...
  - More formal provider governance
  - Evidence based practice
  - Elimination of variation
  - Vendor and supply chain control (minimization of “physician preference”)
  - Quality and clinical outcomes measurement, actionable reporting
  - LOS / Discharge management
  - Integration with primary care (F/U)
• As you go from Left to Right…
  • Close integration with or ownership of…
    o LTACH
    o Rehab
    o Home Health
    o SNF
    o Elderly care
    o Complex institutional care
    o Community care (schools, churches, NGOs)
  • Coordinated care, communication and payment technology platforms
Summary

• More important to consider optimization of clinical programs to encourage risk management

• More provider risk creates resources to reinvest in population health management

• As you move from P4P to full risk you must work in “all four boxes”
  • Structure and Strategy
  • Ambulatory Care
  • Inpatient and Interventional Care
  • Care Continuum

• No matter where you are on the spectrum
  • Engage providers and patients
  • Target difficult disease and operational problems with new approaches