National Best Practices in Hospital and Health System Value-based Payment Innovation and Implementation

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Today's agenda

- *Introduction*
- *The Changing Environment*
  - *Government Strategies*
  - *Market Developments*
- *New VBP Models*
  - *Government (ACOs/BP/CPC+)*
  - *Commercial Models (health plans/employers)*
- *Keys to success*
- *Summary*

Introduction

Introduction

The health care industry is “in the throes of great disruption... the most significant re-engineering of the American health system . . . since employers began providing coverage for their workers in the 1930s.”
- The Economist,

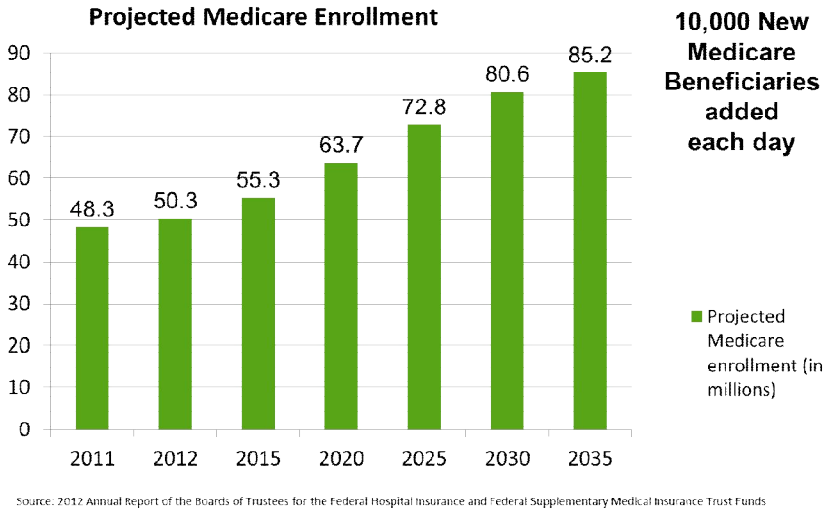
The Economist

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”**

McGraw-Hill Concise Dictionary of Modern Medicine.
The McGraw-Hill Companies, Inc.

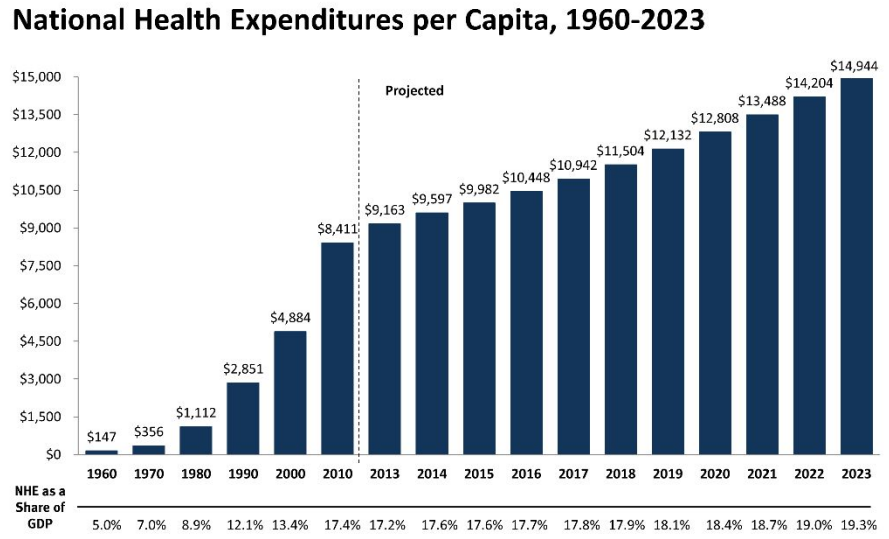
Demographics + Economic Unsustainability + Chronic Disease

1. Aging Population

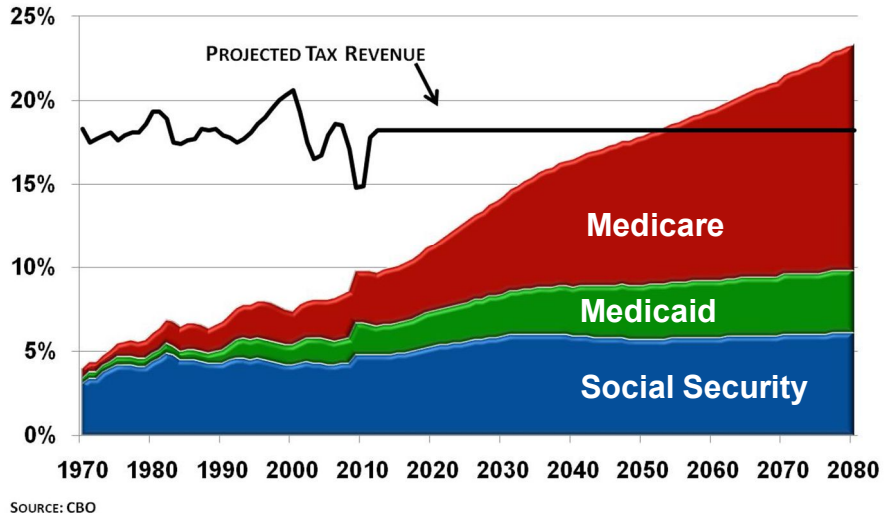


Source: 2012 Annual Report of the Boards of Trustees for the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds

2. Significant Spend Increase

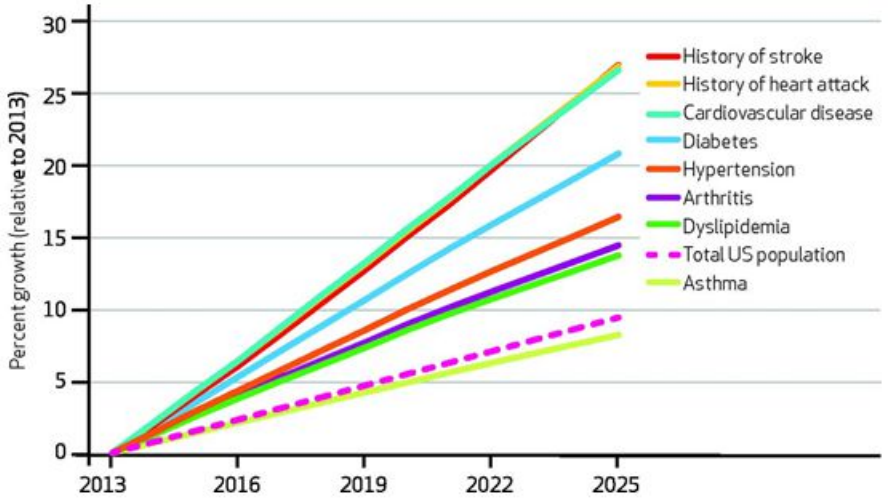


3. Not Fiscally Sustainable



SOURCE: CBO

4. Chronic Conditions



The Changing Environment

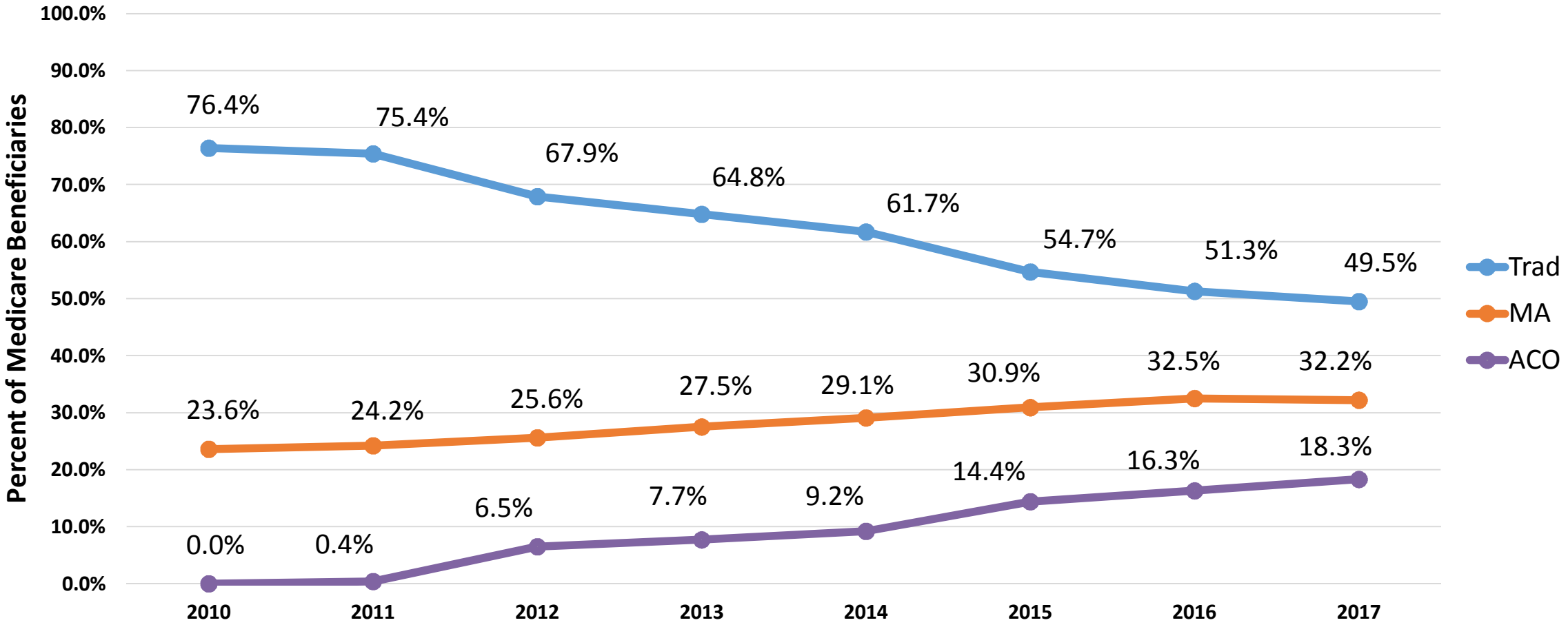
- *Government Strategies*
- *Market Developments*

2016 Major Election Implications

1. There is no new money for healthcare
2. Increased influence of large physician groups
3. Continued growth of value-based payment models
4. Repairing and rebranding of the Affordable Care Act
5. Increased state control/flexibility of Medicaid programs
6. Continued movement toward consumer-driven healthcare
7. Continued growth and increased competition for Medicare Advantage and commercial health plans

Fee for service ↓ Population Health Management ↑

Projection for 2017



Sources:
https://innovation.cms.gov/Files/fact-sheet/nextgenaco-fs.pdf
http://www.markfarrah.com/healthcare-business-strategy/An-Analysis-of-2017-Medicare-Business-Competition.aspx
FFS 2015#: 38 (http://www.cbo.gov/sites/default/files/cbofiles/attachments/44205-2015-03-Medicare.pdf) - 7.9M (the ACO population)= 30.1M
ACO 2016 #: 8.9M (http://www.hhs.gov/about/news/2016/01/11/new-hospitals-and-health-care-providers-join-successful-cutting-edge-federal-initiative.html)
MA 2015#: 17M (http://www.cbo.gov/sites/default/files/cbofiles/attachments/44205-2015-03-Medicare.pdf)

Better Care. Smatter Spending. Healthier People.

Volume to Value

	2016	2018
Track 1: Value-based payments	**85%** of all Medicare payments	**90%** of all Medicare payments
Track 2: Alternative payment models*	**30%** of all Medicare payments	**50%** of all Medicare payments

Focus Areas	Description
Incentives	▪ Promote value-based payment systems – Test new alternative payment models – Increase linkage of Medicaid, Medicare FFS, and other payments to value ▪ Bring proven payment models to scale
Care Delivery	▪ Encourage the integration and coordination of clinical care services ▪ Improve population health ▪ Promote patient engagement through shared decision making
Information	▪ Create transparency on cost and quality information ▪ Bring electronic health information to the point of care for meaningful use

Medicare Access and CHIP Reauthorization Act of 2015

Created in 1997, the SGR capped Medicare physician spending per beneficiary at the growth in GDP

The formula does not incentivize high-quality, high-value care

Since 2003, Congress has passed 17 laws to override SGR cuts

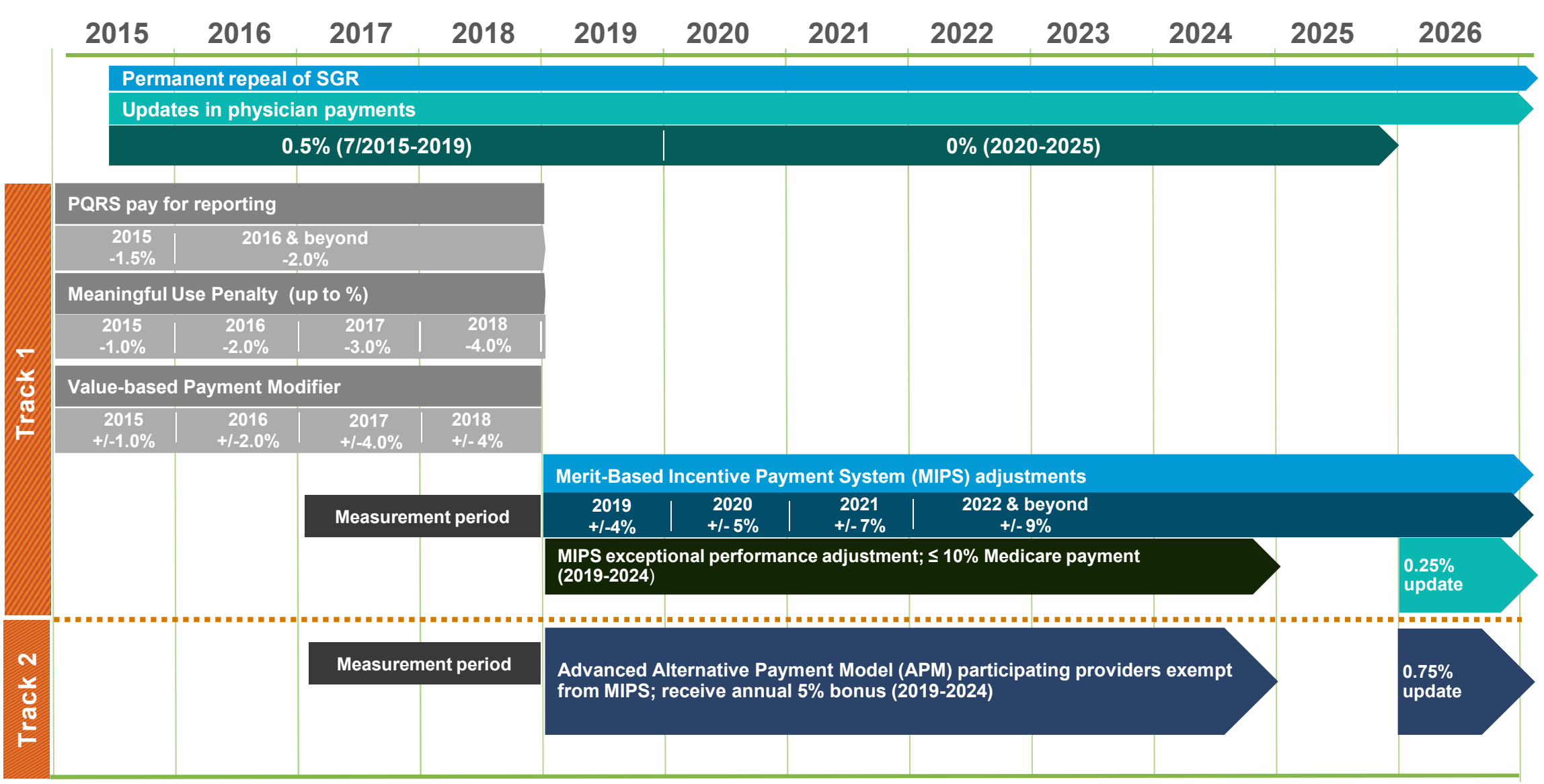
SGR creates uncertainty and disruption for physicians and other providers

Most of $170B in 'patches' financed by health systems

On 3/26/15, the House passed H.R. 2 by 392-37 vote.

On 4/14/15, the Senate passed the House bill by a vote of 92-8, and the President signed the bill.

MACRA Reform Timeline



Greater Price and Quality Transparency

Find & compare doctors, hospitals, & other providers

- Find out about the services they offer
- Make side-by-side comparisons on the care they provide and more
- Get helpful tips on choosing providers and plans

I want to find:

- Hospitals
- Nursing homes
- Home health services
- Dialysis facilities
- Long-term care hospitals
- Inpatient rehabilitation facilities
- Doctors & other health professionals
- Health & drug plans
- Where to get covered medical items

Related Resources

- Find a Medigap policy
- Find suppliers of medical equipment & supplies

Find someone to talk to

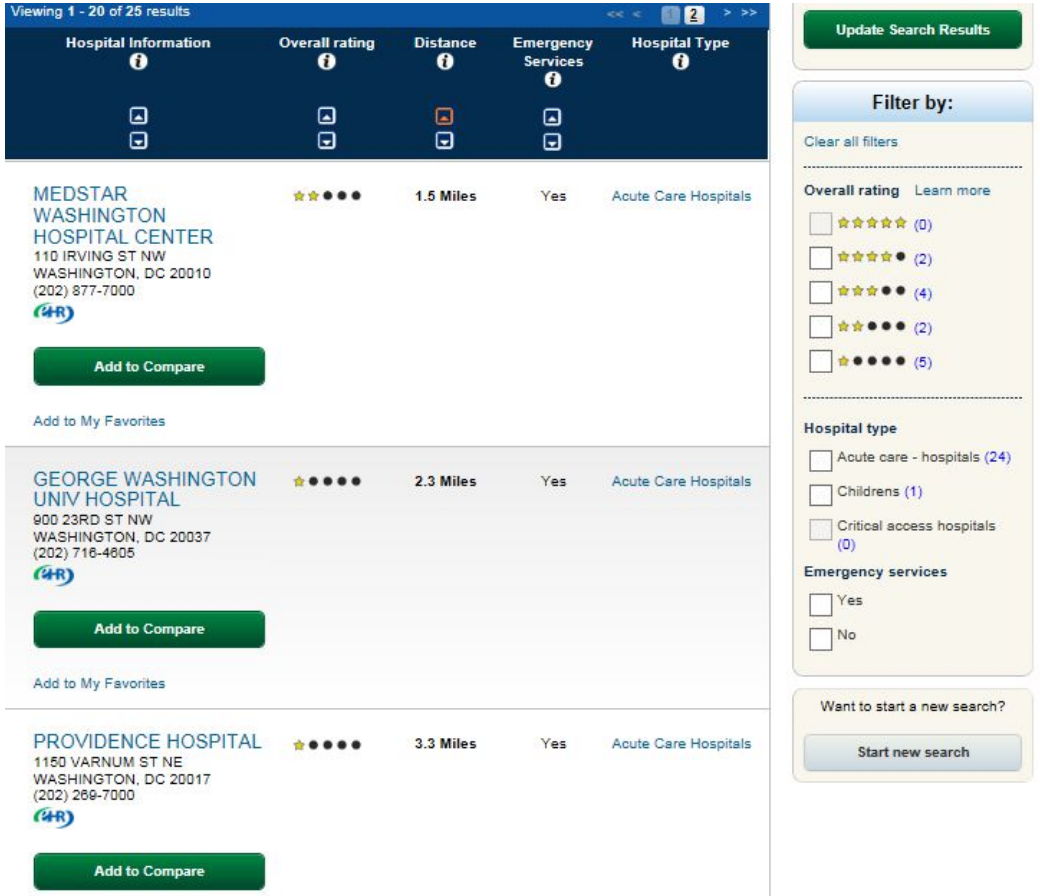
Select your state...

Go

Is your test, item, or service covered?

type your test, item, or service here

Go



Medicare Advantage/"Medicaid Advantage" Growth

- The Trump administration may stimulate growth of **Medicare Advantage** plans and expand similar **"Medicaid Advantage"** models, potentially providing vouchers to Medicaid beneficiaries to purchase commercial Medicaid managed care policies

- The Medicare Advantage program is viewed as a "private voucher" program by many as it removes CMS from the claims processing business

- The proposed new Director of CMS is viewed as an expert in Medicaid VBP (1115) waivers and supportive of the Medicaid voucher program such as the model implemented in Arkansas

Physician/Venture Capital-Owned Healthcare Services

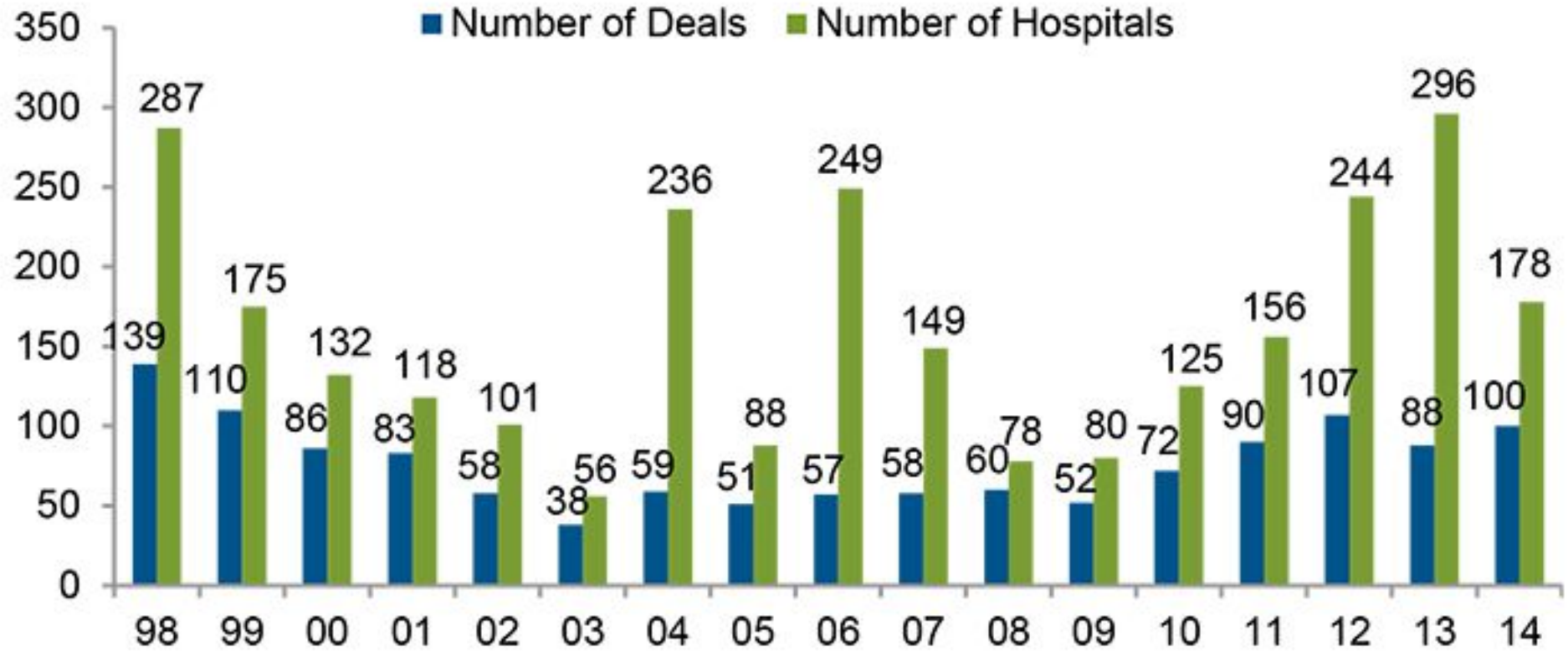
- Continued growth in **physician-owned** and **venture capital-physician-owned** healthcare services to create more price competition for outpatient services

- The new Secretary of HHS (Dr. Tom Price), an orthopedic surgeon favors physician models and we may see a rebirth of physician owned ambulatory surgery centers and hospitals

Provider and Health Plan Consolidation

- **Consolidation** of hospitals, physician groups, health systems, and population health entities are expected to continue in order to expand market reach, and to build scale and efficiencies

Hospital Mergers And Acquisitions, 1998-2014



Graphic Source: American Hospital Association, Trendwatch Chartbook 2015, Chart 2.9

Additional Market Developments

Commercial Health Plans	Provider Sponsored Health Plan growth	Integration of Delivery Systems / health plans	Regional Population Health Efforts / PHSOs / Super CINs	Major Employers / Employer Groups	New disruptive entries / technology	Retail Health Care
•Aetna Health / Provider Sponsored Health Plan four Joint Ventures •United Healthcare (WellMed) Primary care acquisition (over 14,000 physicians)	•Inova •Banner •Sutter •IUH •THR •Aurora •Fairview •Henry Ford •Johns Hopkins •Summa •Baystate	•Highmark Blue Cross bundled payment program •Humana building MSO and employing primary care physicians •United Healthcare/ •Optum efforts to integrate employed physicians with their health plan	•Delaware Valley ACO (2 Philadelphia systems) •Maryland Advanced Health Collaborative (6 organizations) •South Carolina Collaborative (SEHP)	•Pacific Business Group on Health (Centers of Excellence, ACO, PCMH) •Boeing •Lowe's, •Walmart •Lockheed Martin •Booz Allen Hamilton	•Brighton Health / Previa •Aledade •Oscar •Zipari •Endeavor Plus •Wellth	•CVS / Walgreens / Kroger / RiteAid •Kiosk •Aon Hewitt (private exchanges)

New VBP Models

- *Government (ACOs/BP/CPC+)*
- *Commercial Models (health plans/Employers)*

Medicare Shared Savings Initiatives Continue to Grow

Medicare Shared Savings Program

- 99 new Medicare Shared Saving Program (MSSP) ACOs started on 1/1/2017
- 79 ACOs renewed starting 1/1/2017
- 480 total MSSP ACOs as on 1/1/2017
- $656M in shared savings earned across all performance years

Next Generation ACO model

- 28 new Next Generation ACO (NextGen ACO) starting on 1/1/2017
- 45 total NextGen ACOs

Medicare ACO Programs in Totals

- Approximately $960M in
- Over 359,000 clinicians participating in Alternative Payment Models
- More than 12.3 million Medicare and/or Medicaid beneficiaries served
- 572 ACOs across the Shared Savings Program, NGACO Model and Comprehensive ESRD Care Model (CEC)
- 131 ACOs in a risk-bearing track, including in the Shared Savings Program, NGACO, and CEC Model
- 2,893 primary care practices participating in CPC+

Source: CMS.gov; https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2017-Press-releases-items/2017-01-18.html

Medicare ACO Best Practice Example – SW Metropolitan Health System

Networks

- **Medicare A**ccountable **C**are **O**rganization (**ACO**)
- Medicare Shared Savings Program (MSSP) track 1 with 16,000 attributed beneficiaries July 2012 start
  - Year 1: $12.7 million in savings
  - Year 2: $12.6 million in savings
  - Year 3: $18.8 million in savings
- 4 Commercial Population Health Contracts with additional 54,000 covered lives

Key Areas of Focus

- Risk-stratified care management and coordination
  - Managing high risk populations
  - Nurse navigation
- Optimized Post-Acute Care Networks
  - Integration with SNFs and home health initiatives
- Engaged Physicians
  - Physician governance participation
  - Outcomes and participation options
  - Variable payouts
- Enhanced utilization of population health information technology
- Market share growth due to primary care expansion

Medicare ACO Best Practice Example – Southeast Health System

Medicare ACO

Value-based performance

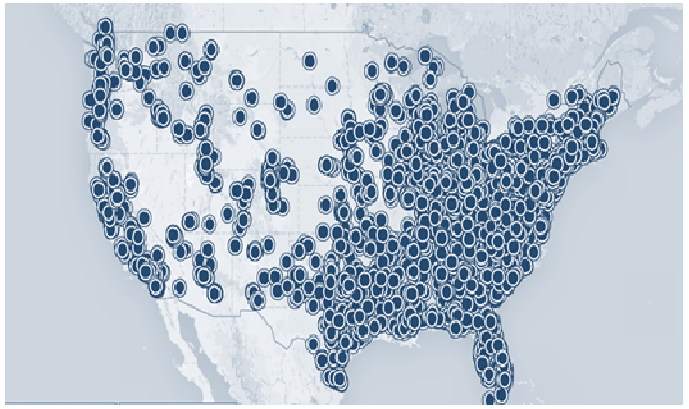
- Started MSSP in 2014
- 2014 MSSP results:
  - Total Savings $5,287,422 (5.6%)
  - Earned Performance Payment $2,590,837
  - Quality – Completed reporting requirements
- 2015 MSSP results:
  - Total shared savings $7,959,265 (9.5%)
  - Earned Performance Payment $3,784,257
  - Quality Score 97.03%
- 4 MA contracts – CIGNA HealthSpring, Aetna Medicare, Humana and United Healthcare
- 3 Commercial and Direct Employer contracts – Aetna, CIGNA and State Health Plan

Key Areas of Focus

- Organizational and Culture Shift
  - Communications and Transparency in Health System Strategy and Operations
  - Medical Staff from Departments to Dyad Leadership to Triad Leadership
- Care coordination:
  - Non-emergent emergency department visits
  - Reduce avoidable readmissions
  - Reduced avoidable hospitalizations
  - Improved engagement with SNF
  - Emergency Department Care Coordinator / Social Worker
  - Managing rising risk patients preventively
  - Managing high risk patients

Bundle Payment Growing Across the Country

Over 7,000 organizations exploring CMS' BPCI



National Market

- ✓ CMS Oncology Bundle
- ✓ IPPS Proposed Rule-CMS Oncology Bundle
- ✓ IPPS Proposed Rule-Expanding BPCI
- ✓ Mandatory CCJR Bundle
- ✓ Mandatory Cardiac and Surgical Hip and Femur Bundle
- ✓ Diane Black- Permanent Voluntary BP Program

Private Market

Humana

United Healthcare

State Markets

Medicaid Bundles

Arkansas

Tennessee

Ohio

Bundle Payment Best Practice Example – East coast

System characteristics

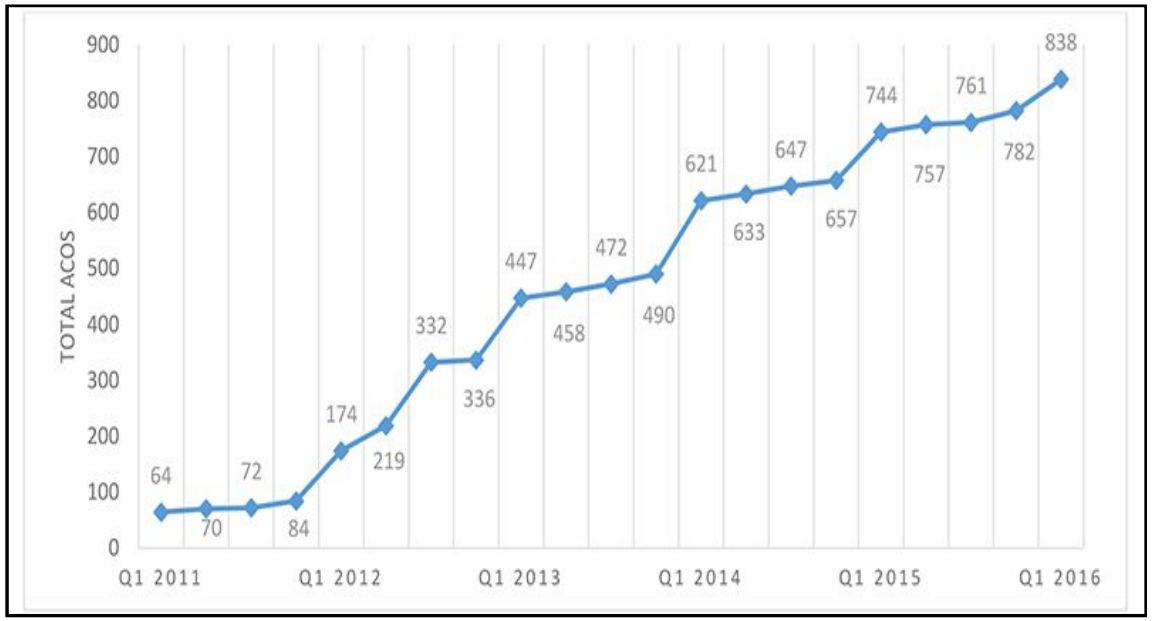
- 80 Locations
- 5,500 Employees
- 971 Providers
- 37,325 ACO lives covered
- Two Hospital System
  - Mainland Campus (Pomona, NJ)
    - 349 Beds
  - City Campus (Atlantic City, NJ)
    - 244 Beds
  - Musculoskeletal Institute
    - 30 bed unit

Key Drivers of Total Joint Success

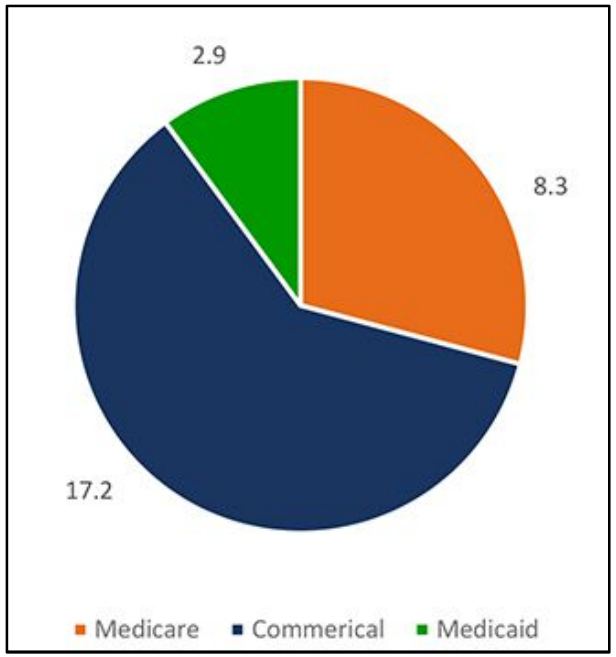
1. Preoperative Expectations and Education
   - Expectation of discharge home post op day 1-2
   - Care Manager discusses discharge plan w/ patient in PAT (2-4 weeks pre-op)
   - RN Navigator calls patient 10 days pre-op
2. Perioperative Optimization Process
   - Medical model, Patient centered
   - Standardized assessment/Algorithm
3. Reduce Post Acute Services
   - RN Navigator/Case Manager pre- and post-op
4. Reduction of Readmissions
   - Admit patients to observation in Ortho Unit
5. Quarterly Review of Data
   - Not intended to be punitive, but to identify opportunities and change process.

Growth of Commercial ACOs

Total Commercial and Medicare ACOs as of 2016



ACO Lives by Payer (Millions)



- 838 active Accountable Care Organizations (ACO) (Commercial and Medicare) across all 50 states and D.C.
- The number of ACO's grew by 12.6% since 2015.
- An estimate of 28.3 million lives are cover by ACOs.

Source: http://healthaffairs.org/blog/2016/04/21/accountable-care-organizations-in-2016-private-and-public-sector-growth-and-dispersion/

Commercial Plans Moving to Value-based Payment

Consistent message – Each payor stated that they are aggressively transitioning to value-based arrangements. Since 2015 each payor's has developed a VBP strategy and has begun to implement in selected markets.

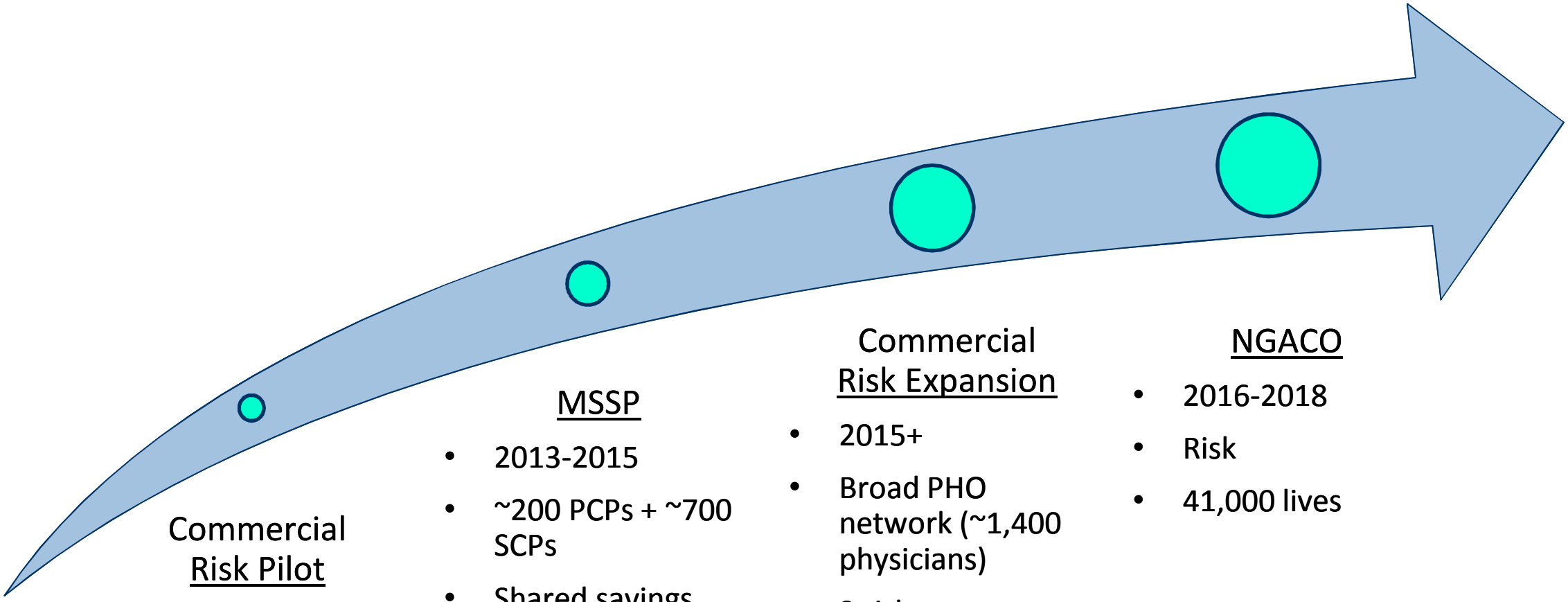
Global Strategy

- ***Anthem*** – 50% shared savings/risk by 2018
- ***Aetna*** – 50% shared savings/risk by 2018
- ***Humana*** – 75% of MA under value-based (with and without shared risk) by 2017
- ***Cigna*** – 50% share savings/risk by 2018
- ***United*** – Committed to VBP but did not provide specifics. Presented a payment transition strategy, which included capitated payment models.

Focus/Goal

- ***Anthem*** – Collaboration / meet you where you are
- ***Aetna*** – Provider sponsored health plans, provider partnerships & JVs
- ***Humana*** – Focus is Medicare Advantage vs Medicare FFS/MSSP
- ***Cigna*** – Prefer to provide supporting tools, data, and services and moving to arrangements with CINs/IDNs
- ***United*** – Overall focus to AC arrangements for commercial, Medicaid, and Medicare (very few CIN arrangements)

Northeastern health system
Value-Based Contracting Strategy



Commercial Risk Pilot

- 2010-2014
- ~200 PCPs
- 2 risk contracts
- 59,000 lives

MSSP

- 2013-2015
- ~200 PCPs + ~700 SCPs
- Shared savings
- 40,000 lives

Commercial Risk Expansion

- 2015+
- Broad PHO network (~1,400 physicians)
- 3 risk contracts
- Several shared savings agreements
- 46,000 lives

NGACO

- 2016-2018
- Risk
- 41,000 lives

Southeastern (SE) region "Super-CIN"

SE Health System

- ~1,200 Physicians
- ~105,000 patients
- 4 shared savings contracts

+

SE Provider Led CIN

- ~300 Physicians
- ~45,000 patients
- 6 shared savings contracts

1,500 Physicians

150,000 Patients

Plan	% Reduction of Medical Cost Trend v. Trend
A	5%
B	4%
C	7%
Cost savings of ~14.2 M across 3 plans	

Results - SE Health System

Plan	% to market or goal
A	2.59% below market
B	2.09 % below market
C	1.3% below market
Cost savings of ~3 M across 2 plans	

Results – SE Provider Led CIN

Health Plan Joint Venture Example

Large National Health Plan & Northeastern (NE) Metropolitan Not-for-profit Health System

- The Health Plan and Health System partnership combines longstanding local, regional and national experience to help improve the cost and quality for Individuals and businesses.
- **The health system provides** – Nationally recognized health care system, and more member management at the primary care level of chronic conditions and lower unit costs.
- **The health plan provides** – Health plan administration, claims and customer service, and best in class online tools for members.
- **Sample of results:**
  - 13% decrease in impactable surgical admissions from 2014 to 2015*
  - Average PMPM costs were flat – From 2014 to 2015 average per member per month costs did not change materially
  - 15% increase in Family Practice visits and 7% increase in Pediatric visits over past two year
  - Medical Pharmacy per member per month (PMPM) cost is down 1%

Keys to Success

Core Components Required for a Successful VBC/P Transformation

Core Components

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

Measurement

Premier's Top Ten Key Steps Taken by Successful Medicare ACOs

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 (3-5% of patients that are currently or are predicted to be the highest utilizers)
5. Establish a process to capture and report 34 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

Keys to Success from the five Major National Health Plans

1. Effective physician leaders with aligned incentive structure
2. Provide actionable and comparable data to the physicians
3. Focused action plans in key areas for improvement
4. Effective care management model
5. Network of high-value post acute care providers
6. Increased capture of utilization in network (>market share)
7. Complete and accurate clinical documentation and coding

A Sample of Key Considerations for Commercial Value-Based Contracts

1. **Expenditure Target Methodology** – Is your target set using a medical loss ratio ("MLR") or trended PMPM?
   - Target multi-year fixed or semi-fixed absolute dollar targets or target the market trend
   - MLR is not a preferred method unless the delivery system has approval of premium setting

2. **Attribution methodologies** – Significant attention and a high level of scrutiny should be applied to the attribution methodology. Poor attribution methodology can lead to detrimental effects.
   - Prospective attribution – Generally believed to be the most beneficial attribution method for provider organizations because it enables proactive, targeted, management of the population.

3. **Care coordination and transformation funding (PMPM) –** Most payers offer some level of funding/PMPM payments for increased care coordination, however their level of scrutiny and requirements have intensified as the demand for this type of funding has increased.
   - Carefully craft and select funding request. Include realistic/achievable outcomes and initiatives with a narrow and concise scope.

4. **Payer/provider data sharing** – Many reports from health plans are too high-level, delayed, or cumbersome.
   - Negotiate language in the VBC contract that protects your organization should claims data be delayed, incomplete, or inaccurate

5. **Aligning and selecting quality metrics** – How can you manage a variety of quality metrics across numerous payers?
   - Negotiate to align quality metrics across payers. Also consider weighting metrics to align with key areas of focus for all payer arrangements.

Summary

Summary

1. Don’t become distracted by the “sound biting” around repeal and replace. Stay focused on executing strategies related to enhancing quality/satisfaction, improving health, and bending the cost curve.

2. Value based payment is here to stay

3. Be proactive/aggressive in partnering and aligning with clinicians.
   - A clinical integrated network can be an effective vehicle
   - Create and build support for your vision.

4. Design and execute a MACRA roadmap that is consistent with VBP strategies.
   - Build a model to align with physicians
   - Develop and implement an APM strategy

5. Be involved state advocacy

6. Optimize tools to improve quality metrics, identify and reduce unjustified variation in quality and utilization, improve productivity, and implement other cost saving steps.

Thank you!

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