Enabling Sustainability Under Value-Based Care

October 28, 2016
Agenda

1. Transition from Volume to Value
2. Foundations of Population Health Management
3. Clinical Integration as a Vehicle
4. Population Health Support Infrastructure
5. Business Case and Financial Sustainability
6. Question and Answer
The Transition from Volume to Value

Coding, Quality Reporting, and Reimbursement Evolving

Changes associates with move from FFS to VBC to Risk-Based Contracting

**Fee-for-Service**
*Recent Past*
- <1-3% of payments value-oriented
- Volume / Admits
- CPT coding
- ICD-9 coding
- Referral
- Pre-authorization

**Value-Based**
*Current State*
- ~10% of payments value-oriented
- HEDIS
- MIPS
- Process Measures
- Outcome Measures

**Risk-Based**
*Future*
- ~70% of payments value-oriented
- PMPM / PMPY
- Total Cost of Care
Medicare to Become Majority of Volume by 2022

Projected Number of Medicare Beneficiaries

$\text{Millions of Beneficiaries}$

<table>
<thead>
<tr>
<th>Year</th>
<th>2014</th>
<th>2016</th>
<th>2018</th>
<th>2020</th>
<th>2022</th>
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<tbody>
<tr>
<td>Value</td>
<td>54.0</td>
<td>55.6</td>
<td>57.3</td>
<td>59.0</td>
<td>60.7</td>
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</table>

Average Inpatient Case Mix By Volume

$n = 785$ Hospitals

<table>
<thead>
<tr>
<th>Year</th>
<th>Self-Pay</th>
<th>Medicaid</th>
<th>Commercial</th>
<th>Medicare</th>
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<tbody>
<tr>
<td>2012</td>
<td>6%</td>
<td>33%</td>
<td>19%</td>
<td>42%</td>
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<tr>
<td>2022</td>
<td>2%</td>
<td>25%</td>
<td>15%</td>
<td>58%</td>
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</table>

CMS Pushes Market Toward Value

MACRA: The Law that Repealed the SGR

New CMS Quality-Based Payment Programs

Merit-based Incentive Payment System (MIPS)

Performance based on 4 categories:
Quality, Resource Use, ACI³, CPIA⁴

Alternative Payment Models (APM)

Financial incentives: 5% annual bonus in 2019-2024, and 0.75% annual payment increase from 2026 on

MACRA-in-Brief

• Legislation passed in April 2015 that repealed the Sustainable Growth Rate (SGR)
• Locks Medicare Part B payment rates at near-zero growth
• Stipulates development of two new Medicare payment tracks
• Extra $500M for exceptional performers under MIPS; APM bonuses estimated from $146M-$429M

Source: H.R. 2: Medicare Access and CHIP Reauthorization Act of 2015; CMS blog "Moving toward improved care through information" (April 2016); Advisory Board Company interviews and analysis.

1) Medicare and CHIP Reauthorization Act.
2) Sustainable Growth Rate.
3) Advancing Care Information (i.e., EHR use).
4) Clinical Practice Improvement Activities.
### Progression of Risk-Based Contracts

Each Stage of Evolution Requires More Sophisticated Capabilities

<table>
<thead>
<tr>
<th>Time Frame</th>
<th>Pay for Performance</th>
<th>Care Coordination Fee/PMPM</th>
<th>Upside Shared Savings</th>
<th>Downside Shared Savings</th>
<th>Capitation</th>
</tr>
</thead>
</table>
| 0-3 years  | - Metric tracking, reporting  
- Disease management, patient activation infrastructure  
- Provider alignment  
- Utilization management | - Metric tracking, reporting  
- Disease management, patient activation infrastructure  
- Provider alignment  
- Utilization management  
- Total cost-of-care measurement | - Metric tracking, reporting  
- Disease management, patient activation infrastructure  
- Provider alignment  
- Utilization management  
- Total cost-of-care measurement  
- Ability to share risk with other providers | - Metric tracking, reporting  
- Disease management, patient activation infrastructure  
- Provider alignment  
- Utilization management  
- Total cost-of-care measurement  
- Ability to share risk with other providers  
- Stop-loss insurance  
- Management of actuarial risk |
Foundation of Population Health Management

**Network Formation**
Develop an aligned provider network that unifies care delivery into a patient-centered coordinated care enterprise.

**Care Model**
Develop and implement comprehensive, scalable and standardized clinical programs and services to deliver high-quality, low-cost care.

**Strategic Operations**
Ensure the organization is supported by an operational structure that enables transformation toward value-based care delivery.

**Financial Management**
Craft a sustainable value-based payment strategy with a solid financial foundation for profitability and growth.

**Information Technology and Analytics**
Technology is critical to success to support delivery system redesign, provider accountability, value-based quality monitoring and patient engagement.
Network Formation

Develop an aligned provider network that unifies care delivery into a patient-centered coordinated care enterprise.

Goal State

- Adequate provider network to support clinical demand
- Governance structure and communications in place to manage network requirements
- Primary care delivery model that supports the full continuum of care
- Comprehensive provider alignment supporting care model requirements
- Cross continuum referral management
Foundation of Population Health Management

Care Model
Develop and implement comprehensive, customized, scalable and standardized clinical programs and services to deliver high-quality, low-cost care.

Goal State
• High-quality standardized care pathways
• Existence of cross-continuum quality program to which all providers are held accountable
• Comprehensive understanding of quality metrics and goals
• Care plans designed around patient stratification
• Seamless care management processes, supported by analytics
• Multidisciplinary care teams maintain unified care plans
• Comprehensive wraparound services and post-acute providers
Foundation of Population Health Management

Strategic Operations

Ensure the organization is supported by an operational structure that enables transformation toward value-based care delivery.

Goal State

- Aligned, well-defined strategic vision across all stakeholders
- Structured population health value proposition and communications strategy
- Participatory governance and leaderships structure
- Centrally defined, dedicated resources and services
- Integration of clinical, financial, and IT analytics to manage populations across the continuum
Foundation of Population Health Management

• Network Formation
  Develop an aligned provider network that unifies care delivery into a patient-centered coordinated care enterprise.

• Care Model
  Develop and implement comprehensive, scalable and standardized clinical programs and services to deliver high-quality, low-cost care.

• Strategic Operations
  Ensure the organization is supported by an operational structure that enables transformation toward value-based care delivery.

Goal State

• Integration of comprehensive data to evaluate value-based care performance and financial net impact
• Analytics span the continuum of care to identify opportunity/risk
• Providers receive consistent, reliable actionable information and incentives tied to quality
• Reporting tailored to stakeholder specific needs
• Consistent evaluation of physician outmigration patterns
• Payer contract analytics and negotiations expertise

Financial Management

Craft a sustainable value-based payment strategy with a solid financial foundation for profitability and growth
Foundation of Population Health Management

Information Technology and Analytics

Technology is critical to success to support delivery system redesign, provider accountability, value-based quality monitoring and patient engagement.

- Unified HIT roadmap that spans across the enterprise
- BI tool combines clinical quality and cost data to enable prospective risk stratification, predictive modeling and provider performance
- Align providers and patient data through HIE/data warehouse
- Informational continuity across the continuum enabling seamless, scalable care management activities
- Value-based contracting reporting and cost management tools
Clinical Integration as a Vehicle to Achieve Population Health Goals

Providers Partner Through Clinically Integrated Network

Clinically Integrated Organization

High Functioning Ambulatory Care Network

Health System

Employed Physicians

Independent Physicians

Network Drives Unified Efforts Toward Care Transformation

Physician Leadership, Governance & Management

Quality Program & Care Management Infrastructure

Business Intelligence & Population Health Solutions

Joint Contracting With Payers
Core Components to be Deemed Clinically Integrated

Defined by the Federal Trade Commission

Clinical Integration is an active and ongoing program to evaluate and modify practice patterns by a network’s physician participants and create a high degree of interdependence and cooperation among the physicians to control costs and ensure quality.

Definition of CI, FTC

Three Core Components

1. **Selective Physician Partnerships**
   A network of physicians opting to collaborate with a Health System in delivering evidence-based care and improving quality, efficiency, and coordination of care

2. **Comprehensive Improvement Initiatives**
   Identified and evolving metrics and targets designed to meaningfully impact clinical practice of all physicians in network to improve value across full continuum of care

3. **Performance Improvement Architecture**
   Data-driven mechanisms and processes to monitor physician performance as well as manage utilization of health care services, to ensure quality of care and control costs

Source: Health Care Advisory Board interviews and analysis.
In order to improve health outcomes, promote economies of scale, and reduce variation across the continuum, a Clinically Integrated Network requires the ability to standardize operations from a clinical, technological and administrative perspective.

These core operations are often housed within a Population Health Services Organization (PHSO).

**Providers Aligned Through Collaborative Care**
- Network includes both independent and system-employed providers
- All providers agree upon and support a clinical quality program
- Network is allowed to collectively negotiate with payers

**Supporting Infrastructure Enabling Value-Based Initiatives**
- Supports CI initiatives and provides the “back office” administrative and IT support for the network
- Has the ability to scale population health capabilities to multiple organizations

**Clinically Integrated Network**

**Population Health Infrastructure**
Leverage Shared Services with a PHSO

What is a Population Health Services Organization (PHSO)?

A PHSO is a centralized entity that allows health care organizations, regardless of ownership or affiliation, to purchase shared services under value-based payment arrangements. It functions like an MSO but support population risk management instead of back-office functions.

Core Services

- Clinical Documentation Improvement
- EHR Implementation and Support
- Group Purchasing
- Bundled Payment Modeling
- Centralized Operations Support

Optional Services

- Care Model Design
- Clinical/Financial Analytics
- IT Solutions and Support
- Value-Based Contracting Support
- Post-Acute Care Partner Profiling

Population Health Services Organization (PHSO)

- Hospitals
- Medical Groups
- Clinically Integrated Networks
- Health Plans

Community Partners

- Post-Acute Providers

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Creating a Virtuous Cycle of Growth

Attaining Financial Returns from Care Transformation

Assemble the Low-Cost Network

Identify and Secure New Lives for Management

Operate Performance-Based Care Network

Total Cost of Care

Successful business model facilitates new growth

Building the Network

Acquiring Lives and Managing Care

Phases
Business Case and Financial Sustainability

Population Health Returns and Investments

Roadmap

Returns

Payments
Enhancements in reimbursement rates

- At-risk population\(^1\) spend reductions
- CMS penalty improvements
- Demand destruction
- Spillover

Net Impact is the sum of the individual components

Market Share
Improved market share driven by PCP referrals

- Increased referrals from employed, ACO, and independent PCPs
- Impact to covered populations outmigration

Efficiency
Management of cost and quality of care delivery

- Enhanced hospital quality
- Improved hospital efficiency

Roadmap

Investments

Incentives
Performance payments to stakeholders

- Physician payments for Shared Savings / Fee-For-Value Contract Performance

Infrastructure
Infrastructure required to support strategy

- Staffing Costs
- Overhead Expenses
- Infrastructure Costs

1) Current anticipated populations

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Pro Forma Reflects a Comprehensive Net Impact

Example Financial Pro Forma for Health System

Pro Forma Components¹

<table>
<thead>
<tr>
<th>Component</th>
<th>Value</th>
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<tbody>
<tr>
<td>Efficiency</td>
<td>$4.2M</td>
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<tr>
<td>Market Share</td>
<td>$11.8M</td>
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<tr>
<td>Payments</td>
<td>$13.4M</td>
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<tr>
<td>Infrastructure</td>
<td>$12.3M</td>
</tr>
<tr>
<td>Incentives</td>
<td>$1.9M</td>
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</table>

Net Impact $15.2M

CIN is predominately a growth strategy and targets mitigating investments early, while contract incentives are realized over a longer time frame.

¹ Numbers represent cumulative value of 3 year Pro Forma

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Expand Population Health Reporting Infrastructure

1. Establish guiding principles for payment transformation
2. Hire clinical / financial analysts
3. Ensure reporting combines quality and financial results
4. Determine communication/dissemination plan and frequency of reporting
5. Align accountability structure with reporting architecture

Example Financial Reports
- Population Health Budget to Variance
- Contract Performance - Overall
- Contract Performance - Individual Plan
- Payer Opportunity / Development Status
- ROI - Major Programs
- Incentive Pool Tracking / Funds Flow
- Individual Physician Incentive Scorecard
- Executive Dashboard
- ROI Summary

Example Clinical Reports
- Risk identification and stratification
- Value-based outcomes reporting
- Care management identification
- Patient Access Monitoring
- Quality Performance Dashboards
- Individual Physician / Group Performance
Return on Investment Summary

Report Displays High-Level Financial Metrics and Net Impact from the CIN

Key Report Considerations:

- Full financial representation of population health activities requires inputs from multiple reports
- High functioning reports provide financial figures, comparisons to budget (or target), and trend
- The ROI report evaluates financial performance, but does not explicitly convey insight; more detailed reports are needed to diagnose key drivers of positive or negative performance
## Best Practice Reporting Merges Clinical/Financial

<table>
<thead>
<tr>
<th>Medical Cost Category</th>
<th>Baseline PMPM</th>
<th>Current PMPM</th>
<th>Trend PMPM</th>
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<tbody>
<tr>
<td></td>
<td>PMPM</td>
<td>Units per 1,000</td>
<td>Paid per Unit</td>
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<tr>
<td>Inpatient Facility</td>
<td>$82.49</td>
<td>45</td>
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<td>Outpatient Facility</td>
<td>$35.25</td>
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<tr>
<td>Emergency Room</td>
<td>$14.54</td>
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<tr>
<td>Pharmacy</td>
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<td>Medical Pharmacy</td>
<td>$26.15</td>
<td>1,100</td>
<td>$110</td>
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<tr>
<td>Lab &amp; Radiology</td>
<td>$20.00</td>
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<td>Home Health</td>
<td>$2.50</td>
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<tr>
<td>Mental Health</td>
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<td>Primary Care</td>
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<tr>
<td>Specialist Care</td>
<td>$56.45</td>
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<tr>
<td>Total</td>
<td>$355.51</td>
<td>22,377</td>
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### Quality Scores

<table>
<thead>
<tr>
<th>Quality Measure</th>
<th>Target Performance</th>
<th>Baseline Performance</th>
<th>Current Performance</th>
<th>PMPM Achievement</th>
<th>Primary Care</th>
<th>Internal Medicine</th>
<th>Cardiology</th>
<th>Gastroenterology</th>
<th>OB/GYN</th>
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<tbody>
<tr>
<td>Quality Measure #1</td>
<td>77%</td>
<td>72%</td>
<td>✓</td>
<td>74%</td>
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<td>72%</td>
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<td>77%</td>
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<td>77%</td>
<td>$0.25</td>
<td>78%</td>
<td>76%</td>
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<td>Quality Measure #3</td>
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<td>69%</td>
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<td>70%</td>
<td>77%</td>
<td>60%</td>
<td>66%</td>
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<td>80%</td>
<td>83%</td>
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<td>Quality Measure #6</td>
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<td>82%</td>
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<td>Quality Measure #7</td>
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<td>Quality Measure #8</td>
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<td>76%</td>
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<td>81%</td>
<td>$0.00</td>
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<td>82%</td>
<td>75%</td>
<td>74%</td>
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<tr>
<td>Quality Measure #9</td>
<td>75%</td>
<td>71%</td>
<td>✓</td>
<td>76%</td>
<td>$0.25</td>
<td>-</td>
<td>-</td>
<td>76%</td>
<td>-</td>
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<tr>
<td>Quality Measure #10</td>
<td>73%</td>
<td>75%</td>
<td>✓</td>
<td>73%</td>
<td>$0.25</td>
<td>73%</td>
<td>76%</td>
<td>70%</td>
<td>70%</td>
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<tr>
<td>Quality Measure #11</td>
<td>75%</td>
<td>70%</td>
<td>✓</td>
<td>68%</td>
<td>$0.00</td>
<td>70%</td>
<td>66%</td>
<td>-</td>
<td>-</td>
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<tr>
<td>Quality Measure #12</td>
<td>75%</td>
<td>82%</td>
<td>✓</td>
<td>85%</td>
<td>$0.25</td>
<td>88%</td>
<td>87%</td>
<td>80%</td>
<td>78%</td>
</tr>
</tbody>
</table>

### Composite Score

<table>
<thead>
<tr>
<th>9 of 12 Achieved</th>
<th>$2.25 PMPM</th>
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</table>

### Cumulative CM Fees

<table>
<thead>
<tr>
<th>Care Management Fees (PMPM)</th>
<th>Maximum Possible CM Fees</th>
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<tbody>
<tr>
<td>$3.00</td>
<td>$324,000</td>
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### PMPM Fees Achieved

<table>
<thead>
<tr>
<th>PMPM Fees Achieved</th>
<th>Annual Savings (in 000)</th>
<th>Percent of Total Achieved</th>
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<tbody>
<tr>
<td>$2.25</td>
<td>$243,000</td>
<td>75%</td>
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</table>

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Four Characteristics That Differentiate CINs

- A highly engaged physician network with aligned incentives
- Investments in capabilities and network assets to match risk profile, such as care management, IT and analytics
- Strong post-acute partnerships and community, non-clinical resources
- Ability to analyze in-network utilization, report on cost and quality, and measure financial performance
Question and Answer