Session 116X
Managing a Successful Transition to Value-Based Payment Arrangements

Presented by:
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Managing a Successful Transition to Value-Based Payment Arrangements

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Disclosure of Relevant Financial Relationships

The following faculty of this continuing education activity has financial relationships with commercial interests to disclose:

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• Premier Inc. – Employed
• Memorial Health System – Consultancy Partner
• IBM – spouse owns stock

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Learning Objectives

• You will learn about the key value based care capabilities that are critical to implementing successful value based payer arrangements
• You will learn about both governmental and commercial value based payment arrangements that are being implemented throughout country
• You will review a case study of an organization that has made a successful transformation to value based payment arrangements
“The success of the people is really the foundation upon which all of their happiness and all of their powers as a state depend.”

Author: Benjamin Disraeli

Agenda

1. Introduction/Purpose
2. Current environment
3. Preparing for value based payment
   a. Value based care (VBC) core capabilities
   b. Integrating VBC and payment
4. Value Based Payment arrangements
   a. Government payers
   b. Commercial payment arrangements
   c. Lessons learned
5. A case study: Memorial Healthcare System
   a. Organizational overview
   b. Value based care/payment strategies
   c. Lessons learned
6. Summary and Recommendations
INTRODUCTION / PURPOSE

The Transformation to Population Health Management

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,
CURRENT ENVIRONMENT

Major Election Implications

- There is no new money for health care
- Affordable Care Act will be “repaired” and rebranded
- Increased influence of large physician groups
- Continued growth of value based payment arrangements
- Increased market competition for pharmaceutical and device firms
- Increased state control and flexibility
- Continued push and growth in consumer driven health plans
- Continued growth and competition for Medicare Advantage and commercial health plan arrangements
Healthcare Spending is Increasing

**National Health Expenditures per Capita, 1960-2023**

- **2011:** $4,727
- **2015:** $5,112
- **2020:** $5,851
- **2025:** $6,915
- **2030:** $8,320
- **2035:** $9,966

**Projected Medicare Enrollment**

- **2011:** 48.3 million
- **2015:** 55.3 million
- **2020:** 63.7 million
- **2025:** 72.8 million
- **2030:** 80.6 million
- **2035:** 85.2 million

- **10k new beneficiaries enroll in Medicare every day.**
- **Number of beneficiaries in Medicare is projected to double by 2035.**

Source: 2012 Annual Report of the Boards of Trustees for the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds
Medicare Spending Continues to Grow

The Medicare Trust fund is projected to be insolvent by 2028, according to the 2016 Medicare trustees' report released in June, 2016.

Cost for Commercial Coverage is Increasing

Source: 2016 Milliman Medical Index; http://www.milliman.com/mmii
Medicaid Accounts for a Large Percentage of State Funds

Cost of Health Insurance Continues to Rise and Out Pace Earnings and Inflation

Projected Growth in Chronic Conditions, 2013-2025

The Affordable Care Act Has Created / Exacerbated Market Forces

Cost Imperative
- Aging population, Medicaid expansion, subsidies
- Government budget strain
- Provider payment cuts/rebalancing
- Insurer competition and consolidation will reduce private plan rates
- Increased efficiency measures, value focus and cost transparency

Increased Consumerism
- Consumer annual choice on public and private exchanges
  - Focus on Value-Based Care
  - High-deductible plans (CDHP)
  - Technology apps and wearables
  - Transparency in costs and quality
  - More “retail” health options (exchanges)

Payment Model Evolution
- Providers accountable for quality and costs
- Alignment of payment models with patient care episodes, not providers
- Focus on population health/value based payment
- Incentives to align private and public payment models and measures

### Better Care. Smatter Spending. Healthier People.

#### Volume to Value

<table>
<thead>
<tr>
<th>Track 1: Value-based payments</th>
<th>Track 2: Alternative payment models*</th>
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<tbody>
<tr>
<td>2016</td>
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<td>85% of all Medicare payments</td>
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#### Focus Areas

- **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

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### 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

* SGR = Sustainable Growth Rate

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

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<td>Permanent repeal of SGR</td>
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### PREPARING FOR VALUE BASED PAYMENT

a. Value based care (VBC) core capabilities  
b. Integrating VBC and payment
Transition to Value-based Payment: Managing Two Worlds

**Pay for volume**
- Fragmented care
- Fee-for-Service
- Treating sickness
- Adversarial payors
- Little HIT
- Lack of outcome based metrics
- Duplication and waste

**Pay for value**
- Accountable care
- Coordinated care across the continuum
- Global payment
- Right care, right setting, right time
- Triple Aim metrics
- Fostering wellness
- Payer partners
- Fully wired systems

The Journey to Population Health Management

**High Performing Hospitals**
- Cost management
- Waste elimination
- Best outcomes in quality, safety
- Satisfied patients
- Physician alignment
- Growth strategies

**High Value Episodes**
- DRG and episode targeting
- Care models
- Gainsharing
- Data analytics
- Cost management
- Physician integration

**Population Management**
- Population analytics
- Care management
- Financial modeling and management
- Legal
- Physician integration and leadership
- Covered lives
Four Stages in the Journey to Population Health Management

1. Preparatory
   - Education
   - Inventory
   - Assessment
   - Gap analysis
   - Operational plan

2. Transformational
   - Primary care network
   - Patient Centered Medical Home
   - Clinical integration
   - Care management
   - Network development
   - Health informatics

3. Implementation
   - Defined populations
   - Payer partners

4. Expansion
   - Employee health plan
   - Commercial arrangement
   - Medicare MSSP
   - Medicare Advantage
   - Medicaid
   - Employer contracting
   - Uninsured

Crossing the Bridge From FFS to Value-Based Models

Current FFS System

Value-Based Care/Payment models

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

Measurement

What are the underpinning building blocks?
Transforming of Healthcare to Value-Based Delivery Models

- Patient Centered/Engaged
- Leadership/Cultural Transformation
- Primary Care Based/Patient Centered Medical Home
- Physician Led Clinical Integration
- Care Management Program
  - High Risk Populations
  - Chronic Disease Management
  - Transition of Care/Post-acute Care
- Integrated Delivery Systems
- Evidence Based Care Models
- Electronic Medical Record/Data Analytics
- Triple Aim Metrics/Improve Value
  - Health of the Population
  - Cost Per Capita
  - Patient Quality/Satisfaction/Engagement

ACO / Clinically Integrated Structure

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<td>HIE</td>
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Delivery System Care Coordination Framework

Managing the Care of a Population

Acute Care
- Care Coordination within the site
- Transitions between sites of care

PCMH
- Complex Care Management
- Transitions between providers
- Chronic Care (DM)
- Wellness/Risk Reduction

Post Acute
- Transitions between sites of care
- Care Coordination within the site

Information Systems
Evidence-Based Care
Analytics/Reporting

Community

Integrating VBC Redesign & New VBP Arrangements

**VB Care Redesign**
- Patient Centered Medical Home
- Clinical Integration
- Care Management
- Post-Acute Care
- Electronic Health Record
- Data analytics

**VB Payment Arrangements**
- Care Transformation Costs
- Care Management Payment
- Shared Savings
- Episodes of Care Payment
- Global Payment

Care redesign must not outpace changes in payment

Value-Based Transformation
VALUE BASED PAYMENT ARRANGEMENTS

a. Government payers
b. Commercial payment arrangements
c. Lessons learned

Government Developments

- National Policy Developments
  - HHS Announcement (1/26/15) to increase speed of the transformation to value based payment/CMS Learning center
  - New Oncology Care Model and CJR Bundled Payment Program
  - Mandatory bundled payment final rule release on 12/20/16 for heart attack treatment, bypass surgery, and surgical hip and femur fracture treatment
  - Next Generation ACO Model
  - SGR proposed fix with physician incentives to value based payment programs
  - Revised MSSP benchmarking rule released in June, 2016 (400+MSSPs)
  - MACRA passed in April, 2015 and implemented in January, 2017
  - CPC+ begins on January 1, 2017 and round 2 opens up to payer applicants in April, 2017
  - New Advanced Alternative Payment Models (AAPMs) to be released in 2017

- State Reform Developments
  - SIM state planning grants (AZ, KY, VA, MD, WI, etc.)
  - Expansion of private Medicaid model (IA, PA, AR, UT, IN)
  - Episodes of Care Medicaid model (AR, TN, OH)
  - ACO Model (OR, CO, AL,)
  - DSRIP Model (TX, CA, NJ, NY, MA)
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 (NGACO) starting on 1/1/2017
- 45 total NGACOs

**Medicare ACO programs in total**
- Approximately $960M in savings
- 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://innovation.cms.gov/initiatives/bundled-payments/](https://innovation.cms.gov/initiatives/bundled-payments/)

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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

**Commercial/MA Market**
- Humana
- United HealthCare

**State Market**
- Medicaid Bundles
  - Arkansas
  - Tennessee
  - Ohio

Source: CMS.gov; [https://innovation.cms.gov/initiatives/bundled-payments/](https://innovation.cms.gov/initiatives/bundled-payments/)
Comprehensive Primary Care Plus
Medicare is Partnering with Aligned Public & Private Payers

Source: CMS.gov; https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus

Trend: Fee for service ↓ Population Health Management ↑

Sources:
Current State of Medicaid Expansion


Adopted (32 States including DC)
Not Adopting At This Time (19 States)

The New Wave of State Reforms

ACOs: 7
DSRIP: 3
DSRIP & ACOs: 7
Bundled payment: 3
Global budget 2
ACO & GB: 1
Planning Reform 14
Growth of Commercial ACOs

- 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 covered by ACOs.


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.

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<td><strong>Anthem</strong> – 50% shared savings/risk by 2018</td>
<td><strong>Anthem</strong> – Collaboration / meet you where you are</td>
</tr>
<tr>
<td><strong>Aetna</strong> – 50% shared savings/risk by 2018</td>
<td><strong>Aetna</strong> – Provider sponsored health plans, provider partnerships &amp; 4 JVs</td>
</tr>
<tr>
<td><strong>Humana</strong> – 75% of MA under value-based (with and without shared risk) by 2017</td>
<td><strong>Humana</strong> – Focus is Medicare Advantage vs Medicare FFS/MSSP</td>
</tr>
<tr>
<td><strong>Cigna</strong> – 50% share savings/risk by 2018</td>
<td><strong>Cigna</strong> – Prefer to provide supporting tools, data, and services and moving to arrangements with CINs/IDNs</td>
</tr>
<tr>
<td><strong>United</strong> – Committed to VBP but did not provide specifics. Presented a payment transition strategy, which included capitated payment models.</td>
<td><strong>United</strong> – Overall focus to AC arrangements for commercial, Medicaid, and Medicare (very few CIN arrangements)</td>
</tr>
</tbody>
</table>
ACOs by state: Commercial and Medicare

ACOs by State


Commercial Developments

<table>
<thead>
<tr>
<th>Commercial Health Plans</th>
<th>Provider Sponsored Health Plan growth</th>
<th>Integration of delivery systems / health plans</th>
<th>Regional Population Health efforts / PHSOs under development / Super CINs</th>
<th>Major employers / Employer Groups</th>
<th>New disruptive entries / technology</th>
<th>Retail Health Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna Health, Provider Sponsored Health Plan JV's</td>
<td>United Healthcare (WellMed) -- Primary care acquisition (over 14,000 physicians)</td>
<td>Highmark Blue Cross bundled payment program</td>
<td>Delaware Valley ACO (2 Philadelphia systems)</td>
<td>Pacific Business Group on Health (Centers of Excellence, ACO, PCMH)</td>
<td>Brighton Health / Previa</td>
<td>CVS / Walgreens / Kroger / RiteAid</td>
</tr>
<tr>
<td>United Healthcare (WellMed) -- Primary care acquisition (over 14,000 physicians)</td>
<td>Proposed Aetna / Humana and Anthem / Cigna mergers blocked by Justice Dept.</td>
<td>Humana building MSO and employing primary care physicians</td>
<td>Maryland Advanced Health Collaborative (8 organizations)</td>
<td>Aledade (20 MSSPs in 15 states)</td>
<td>Oscar</td>
<td>Buffett</td>
</tr>
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<td>Oscar</td>
<td>Buffett</td>
</tr>
</tbody>
</table>
Keys to Success from Perspective of Major Health Plans

• Effective and passionate physician leaders with aligned physician incentive payment structure
• Provide actionable and comparable data to physicians
• Focused action plans in key areas in have improvement
• Effective care management processes
• Network of high-value post acute care providers
• Increased capture of utilization in network (market share growth)
• Complete and accurate coding for risk acuity adjustment
  • Some encourage providers with an MSSP to have a complementary Medicare Advantage program/contract

Premier’s Top Ten Key Steps to build Successful 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 (2-3% 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
Common Barriers to Success

- Leadership commitment and vision
- Cultural change
- Size / market presence
- Financial resources
- Physician relations/leadership
- Lack of primary care network
- Information technology

Value-based payment (VBP) models

<table>
<thead>
<tr>
<th>Model</th>
<th>Participants</th>
<th>Revenue Match</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Risk (Clinical &amp; Actuarial Risk):</td>
<td>Employee Health Plan</td>
<td>20,000</td>
</tr>
<tr>
<td>Capitated Risk:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shared Risk (Clinical Risk):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bundled Payment:</td>
<td>Comprehensive Care for Joint Replacement Model</td>
<td>35,000</td>
</tr>
<tr>
<td>Shared Savings:</td>
<td>United Healthcare</td>
<td>15,000</td>
</tr>
<tr>
<td></td>
<td>Cigna</td>
<td>10,000</td>
</tr>
<tr>
<td></td>
<td>Blue Cross</td>
<td>23,000</td>
</tr>
<tr>
<td></td>
<td>MSSP ACO</td>
<td>40,000</td>
</tr>
<tr>
<td>Care Management/</td>
<td>Medicare VBP (admissions)</td>
<td>5,000</td>
</tr>
<tr>
<td>Medical Home PMPM:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pay for Performance/Bonus:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fee for Service (with quality incentives):</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The Successful Transition to Value-Based Payment Arrangements

Matt Muhart, EVP & CAO

Agenda

1. Organizational Overview
2. Value-Based Care / Payment Strategies
3. Lessons Learned
Memorial Healthcare System (Overview)

- Independent Special Taxing District Created in 1953
- Seven-member Board of Commissioners appointed by the Governor of Florida
- Authority to levy ad-valorem taxes; 2.1132 mills in 1997, down to 0.1615 mills in 201
- Longstanding tradition of serving the community of South Broward as the safety net provider
- High-level Financial Overview:
  - $1.897B in net revenues
  - $1.882B in net assets
  - AA Bond Rating by Standard & Poor’s; Aa3 bond rating with Moody’s

Memorial Healthcare System

System Highlights:

- Six Hospitals; 1,889 Beds
- Level I Trauma Center
- Level II & III NICU
- Open Heart Program (STS Three-Star Rating)
- Adult & Pediatric Heart Transplant Programs
- IP/OP Psychiatric Services
- Kidney Transplant in 12 months
- 120-Bed Skilled Nursing Facility
- Home Health Agency
- Level 3 Patient Centered Medical Home Primary Care Clinics
Population Health Management Defined

PHM is a sophisticated care delivery model that involves a systematic effort to assess the health needs of a target population and proactively provide services to maintain and improve the health of that population.

Population Identification

Health Assessment

Risk Stratification

Health Continuum

Illustrative Population Health Management Interventions

Preventative Services | Lifestyle Coaching | Transitional Care | Complex Case Management | Palliative and End-of-Life Care

*Framework adapted from Care Continuum Alliance’s Achieving Accountable Care: Essential Population Health Management Tools for ACOs, April 2011.
Growth – The Importance of Scale

• Law of Large Numbers
  o Achieve optimal medical risk distribution

• Basic Infrastructure Is Very Expensive
  o What is needed for a large number of lives is also needed to a small number of lives

• How to Grow?
  o Organic Growth
    ▪ Attract more PCPs
    ▪ Attribute unattached lives to PCPs
      • Mine ED & UCC visits
  o External
    ▪ Create Super CIN
      • Single platform with plug-and-play sub-networks
### Current Scale of Population Health Initiatives

<table>
<thead>
<tr>
<th>Model</th>
<th>Commercially Insured</th>
<th>Medicaid</th>
<th>Uninsured</th>
<th>ACA-Exchange Insured</th>
<th>Medicare FFS</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Value Based-Shared Savings</td>
<td>150,000</td>
<td>993</td>
<td></td>
<td>9,380</td>
<td>10,203</td>
<td>170,576</td>
</tr>
<tr>
<td>Full Risk Transfer</td>
<td>44,300</td>
<td>7,840</td>
<td></td>
<td></td>
<td></td>
<td>52,140</td>
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<tr>
<td>FFS</td>
<td>9,000</td>
<td>661</td>
<td></td>
<td>1,546</td>
<td></td>
<td>11,207</td>
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<tr>
<td>ASO</td>
<td>25,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>25,000</td>
</tr>
<tr>
<td>Total</td>
<td>159,000</td>
<td>70,954</td>
<td>7,840</td>
<td>10,926</td>
<td>10,203</td>
<td>258,923</td>
</tr>
</tbody>
</table>

*Numbers represent current population served in each category

---

**ACHN: A “Super-CIN”**

Holy Cross Physician Partners and Memorial Health Network were the first-to-market with Clinical Integration in South Florida, successfully delivering quantifiable value to the community

- **Memorial Health Network**
  - ~1,200 Physicians
  - ~105,000 patients
  - 4 shared savings contracts

- **Holy Cross Physician Partners**
  - ~300 Physicians
  - ~45,000 patients
  - 6 shared savings contracts

---

1,500 Physicians
150,000 Patients
Regional Collaboration

The joint network enhances the ability to be able to provide the right care, in the right place at the right time.

Legend:
- HCPs
- MHN Specialists
- HCP on IPs
- MHN IP Specialists

45,000 HCPP Current Covered Population

105,000 MHN Current Covered Population

Source: CIN physician rosters. Note: PCPs include Family Practice, Internal Medicine, General Pediatrics and Geriatrics. Covered patients include commercial, employee health plan patients and Medicare Advantage.

Operating Model

Sharing of best practices and intellectual capital to advance integration efforts.

- Memorial Health Network
- Holy Cross
- Physician Partners
- Other CINs
- Other Partners
- Hospital & Physician FFS
- Payer Contracts
- Hospital & Physician FFS
- Payer Contracts
- Hospital & Physician FFS
- Payer Contracts
- Hospital & Physician FFS
- Payer Contracts
Governance / Infrastructure

**ACHN Board of Managers**
- Provides overall leadership and fulfills duties as specified by the Operating, Affiliation and Network participation agreements
- Physician led, leadership rotates amongst member CINs on annual basis
- Equal representation from CIN members

**Quality and IT Committee**
- Oversees quality performance, reporting and technology needs of the joint network
- Physician led, leadership rotates amongst member CINs on annual basis
- Equal representation from CIN members

**Finance and Contracting Committee**
- Oversees the payer strategy, contracting and finance activities of ACHN
- Physician led, leadership rotates amongst member CINs on annual basis
- Equal representation from CIN members

**Growth and Development Advisory Group**
- Oversees ACHN non-contracting growth strategy and service offering development

**Executive Director**
- Manages day-to-day operations of ACHN
- Administrator led

Sample Physician Progress Report
Progress Report (Page 2)

Sample Physician Care Gap Report
### Cost Control

Member CINs have a track-record of improving quality and care coordination, while containing costs, resulting in a savings of $17.2M in 2015.

<table>
<thead>
<tr>
<th>Plan</th>
<th>% to market or goal</th>
<th>Plan</th>
<th>% Reduction of Medical Cost Trend v. Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>2.59% below market</td>
<td>A</td>
<td>5%</td>
</tr>
<tr>
<td>B</td>
<td>2.09% below market</td>
<td>B</td>
<td>4%</td>
</tr>
<tr>
<td>C</td>
<td>1.3% below market</td>
<td>C</td>
<td>7%</td>
</tr>
</tbody>
</table>

Cost savings of ~3 M across 2 plans

Cost savings of ~14.2 M across 3 plans

### Lessons Learned

- Studied CMS Cardiac Bundles but did not pursue, missing a great opportunity to practice
- Identify physician leaders who “get it” from the start
- Underestimated the length of time needed to solidify physician “buy-in”
- Incentive distribution models: some will work as intended, some won’t
- Don’t build the perfect, complete infrastructure on day one, but don’t wait until it’s too late
SUMMARY AND RECOMMENDATIONS

The Shift from Volume to Value is gaining momentum and speed

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”

The McGraw-Hill Companies, Inc.
**Current Areas of Marketplace Focus**

1. MACRA related strategies (MIPS and MIPS/APM reporting, journey to AAPMs)
2. Regional consolidation/affiliations
3. Statewide/regional super CINs
4. Managing post-acute services/costs/utilization
5. Implementing care management programs across the continuum
6. Physician leadership development programs
7. Employed and physician network performance improvement
8. Preparing for and implementing two-sided risk arrangements

**Current Areas of Marketplace Focus (continued)**

9. Improving financial performance of commercial Value-Based Payment arrangements
10. Implementing/expanding episode of care/bundled payment arrangements
11. MSS Benchmarking/Performance Improvement
12. Bundled Payment services (gainsharing, and analytics)
13. Searching for effective PHIT solutions
14. Medicaid reform (focus on high risk/per capita cost)
15. Managing pharmacy costs
Future Projections

1. The speed of the transformation to value-based care and payment models to increase and accelerate, while payment pressures on fee-for-service models grow.

2. MACRA to prevail and become both an economic opportunity, and threat to physicians and health systems.

3. An increase in the number of consumer-driven health plans, and greater price and quality transparency to cause consumers to be more price sensitive and involved in their personal health and healthcare decisions.

4. The Trump administration to stimulate growth of Medicare Advantage plans and expand similar "Medicaid Advantage" models, potentially provide vouchers to Medicaid beneficiaries to purchase commercial Medicaid managed care policies.

5. More employers to contract directly with integrated delivery systems and clinically integrated networks to align incentives through shared savings arrangements and lower administrative costs.

6. CMS to release additional physician-led Medicare payment models (similar to CPC+) providing physicians and physician groups the opportunity to lead payment models and accept additional risks/rewards.

Future Projections (continued)

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

8. Demand for greater price and quality transparency to continue as consumers become more responsible for first dollar and a greater percentage of their healthcare costs.

9. Consolidation of hospitals, physician groups, health systems, and population health entities to continue in order to expand market reach, and to build scale and efficiencies.

10. The Affordable Care Act to be “politically” repealed, however many key aspects to be retained, and either rebranded or privatized.

11. Information technology opportunities to continue to improve in several areas, including both analyzing claims data and managing populations, patient communication, and remote and wearable monitoring services, all of which will enhance transparency.

12. Investments and research in precision medicine programs to grow significantly to integrate genetic, clinical and claims information, and the social determinants of health into both predictive and personalized treatment models.
Recommendations

1. Don’t get distracted by the “sound biting” around repeal and replace. Stay focused on executing strategic responses.
2. Be proactive and aggressive in partnering aligning with clinicians and building payment alignment.
   - Create and build support for your vision.
3. Design and execute a MACRA roadmap.
   - Integrate MACRA strategy with VBC/P and Population Health Strategies
   - Leverage MACRA to create greater alignment with physicians
   - Identify your APM/AAPM strategy
4. Be actively involved state and federal advocacy.
5. Optimize tools to improve quality and cost position, identify unjustified variation, productivity improvements, and other savings.

Thank you!
Presenter Biography & Contact Info

Joseph F. Damore, FACHE is Vice President of Population Health Management (PHM) at Premier, Inc. He is responsible for assisting physician groups, hospitals and health systems, health plans, and integrated health systems in implementing population health management arrangements, including Accountable Care Organizations. His responsibilities include leading Premier’s Population Health Management team that provides collaborative and consulting services. He and the PHM team provide consultative assistance and advice to numerous health care organizations in areas such as strategic business planning, clinical integration, new value based payer arrangements, quality and financial improvement, and in implementing population health management core capabilities.

Prior to joining Premier, Mr. Damore served as the President/CEO of Mission Health System in Asheville, NC from 2004 to 2010 and Sparrow Health System in Lansing, MI from 1990 to 2004. He also served in leadership positions with the Greenville Health System (SC) and Mercy Health Services (now CHE Trinity Health). His entire thirty plus year career as a health care leader has focused on building and developing regional integrated health systems, including integrating comprehensive delivery systems and health plans and building several provider sponsored health plans.

Email: Joe_Damore@Premierinc.com

Presenter Biography & Contact Info

Mr. Muhart joined the Memorial Healthcare System in 1998. As EVP-CAO, he leads Population Health Initiatives, Finance, Information Technology, Business Intelligence, Process Improvement, Revenue Cycle, Supply Chain, Treasury and Property Management. Prior to serving as EVP-CAO, he was the SVP-CFO for Memorial. Prior to joining Memorial, Mr. Muhart held positions at Columbia/HCA and Ernst & Young.

For the last several years, his primary focus has been on Memorial’s population health initiatives in which he led the development of Atlantic Coast Health Network (ACHN), a “Super-CIN” owned by Memorial and Holy Cross Hospital covering approximately 150,000 lives in a value-based payment arrangement. He serves on the boards of ACHN, Memorial Health Network (a subnetwork CIN under ACHN), Broward Guardian/MSSP ACO with approximately 9,700 lives) and finally he serves on the finance committee of Community Care Plan, a Medicaid Provider Services Network covering 43,000 Medicaid beneficiaries.

Email: MMuhart@mhs.net
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