Population Health Management Arrangements: What’s Working and Why?

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Today’s Agenda & Learning Objectives

• Introduction/Purpose
• Why Population Health Management Now?
  – Gain a greater understanding of the changing health care environment in the U.S.
• The Current Population Health Environment
  – Gain an understanding of the current population health management environment
• What’s working and Why
  – New Care Models
  – New Payment Models
• Summary
INTRODUCTION / PURPOSE

The Transformation to Population Health Management

FAD 2010  TREND 2012  REALITY 2015

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”

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Population Health “… the health outcomes of a group of individuals, including the distribution of such outcomes within the group.”

Wikipedia, the free encyclopedia
“WHEN WE ARE NO LONGER ABLE TO CHANGE A SITUATION – WE ARE CHALLENGED TO CHANGE OURSELVES.”

VIKTOR E. FRANKL
“MAN’S SEARCH FOR MEANING”

WHY POPULATION HEALTH MANAGEMENT?
WHY NOW?
Increasing Market Pressure

**Federal**
- Current Medicare enrollment is projected to increase from approximately 54M today, to 85M by 2035
- Dramatic projected growth of all major chronic diseases
- FFS payment cuts

**State**

**Employee / Commercial**

ACO Development Accelerating Nationwide

**Nearly 700 public and private ACOs in every state and 7.8M Medicare lives in MSSPs**

**Medicare-specific ACOs:**
- 32 CMMI “Pioneer” participants, program began 1/1/2012; 9 dropped out with 7 converting to MSSP 1/1/2013; 4 dropped in 2014 with 2 converting to MSSP
- Medicare Shared Savings Program
  - 4/1/2012: 27 ACOs added
  - 7/1/2012: 89 ACOs added
  - 1/1/2013: 106 ACOs added
  - 1/1/2014: 123 ACOs added
  - 1/1/2015: 89 ACOs added

**Percent of population covered by an ACO**

**Composition of ACOs**

**Number of ACOs**

<table>
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<tr>
<th>Physician Group</th>
<th>Hospital</th>
<th>Insurer</th>
<th>Other</th>
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THE CURRENT POPULATION HEALTH MANAGEMENT ENVIRONMENT

Market Developments

- Growing movement to population health arrangements
- Multi-owner regional population health entities
- Growth/interest in provider sponsored health plans
- Medicare Shared Savings participation growth (over 400)
- CVS converts from retail Rx to population health
- MSSP Mergers/consolidation/growth
- State Medicaid models
  - ACO models (Oregon, Alabama, etc.)
  - Episode of Care/Bundled Payment models (AR, TN, OH)
  - DSRIP model (TX, CA, NJ, NY)
  - Commercial Medicaid expansion (AK, IA, UT, PA)
- Commercial Payor developments
  - Shared Savings models (Aetna, Cigna, Humana, Anthem, UHC, and multiple BC plans)
  - Direct contracting shared savings models (Aetna)
Market Response

- Growth in Consumer Driven Health Plans and commercial shared saving agreements continuing (2nd wave)
- Emerging application of accountable care principles to Medicaid programs (e.g., Maryland, Alabama, Arkansas, Illinois, NY, Oregon, NC, etc.)
- Significant growth in the number of MSSP applicants for 1/01/15 start date (89 new participants)
- Declining hospital inpatient admissions due to care management programs (e.g., 6% decrease in the Chicago market over the past 48 months)
- Growth in Patient Centered Medical Homes (30,000+ primary care physicians participating to date)
- Implementation of state health insurance exchanges (over 7.5 Million)
- 10 Million newly insured (Uninsured rate dropped from 17.5% to 12.4%)

Early Results Indicate the Effectiveness of ACOs

- Medicare costs per capita grew 0.8% in 2012 (while Pioneers grew at 0.3%)
- Physician Group Practice (PGP) Demonstration Project reduces cost of Dual Eligibles by $532 per year
- All 32 initial Pioneer ACOs achieved quality improvements
- 2/3 of Pioneer ACOs achieved cost savings in 2012
- Group Health and Geisinger report findings that team-based medical homes reduced per capita spending 7-8%
- Montefiore achieved $14M in shared savings in 2011, due in large part to a 10% decline in hospital admissions
- Mosaic Life, Hackensack, Banner Health, and WellStar generate significant shared savings in MSSP by reducing cost per capita
- Oregon’s new Medicaid program reports early success (1% decline in per capital costs in first year)
WHAT’S WORKING AND WHY: BUILDING NEW CARE MODELS

Four Stages in the Journey to Population Health Management

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

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

3. Implementation
   - Defined population
   - Payor partner
   - Post-acute

3. Expansion
   - Employee health plan
   - Commercial arrangement
   - Medicare
   - Medicaid
   - Employer contracting
   - Uninsured
Integrating New Care Models and New Payment Models

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

Care redesign must not outpace changes in payment

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

Population Health Transformation

Care Transformation: Creating Alignment/Integration

- Primary Care Network Development
- Physician Led Clinical Integration
- Patient Centered Medical Home
- Care Network Development/Alignment
- Care Management Program
  - High Risk Population
  - Chronic Disease Management
  - Care Transitions/Post-acute care
  - Episodes of Care
- Health Information Tools
  - EMR
  - HIE / Interface Engine
  - Claims Analytics / Predictive Modeling
  - Care Management (Evidence-Based)
- Patient Engagement / Satisfaction
- Triple Aim-based Metrics
- Leadership / Cultural Transformation
Patient Centered Medical Home Model

PCMH Expected Attributes:
• NCQA / other certification
• Adoption of standard IT system
• Use of care coordinators/managers
• Focus on team-based approach to care

Health System Support:
• Provide access/support of IT adoption within PCP office
• Educate and provide training to PCP’s regarding PCMH adoption
• Assist with care redesign
• Jointly hire and train care coordinators/managers
• Collaborate across practices to develop performance based metrics focused on quality, safety, care coordination and costs

PCMH – Success Stories

• **Hill Air Force Base** of Utah improved blood sugar control for 77% of their diabetic population, reduced cost increases by approximately 10%, and improved patient satisfaction to 95%

• **CareFirst Blue Cross Blue Shield** of Maryland yielded an estimated 15% PMPM savings in the first year and $98 million in savings over two years

• **Group Health of Washington** reported overall cost savings of $17 PMPM including 29% fewer ER visits and 11% reduction in hospitalizations for ambulatory sensitive conditions

• **Oklahoma Medicaid** reported $29 PMPM savings

• **HealthPartners** in Minnesota reported 39% reduction in ER visits, 24% fewer hospitalizations, 40% reduction in readmission rates and 20% reduction in inpatient costs

• **United Healthcare (UHC)** reported an average 6.2% reduction in cost per capita in four states

• **Michigan Blues (BCBS)** reported $155M in savings over the first three years of the program. They also estimate, 3.5% higher quality measures, 5.1% higher preventive care measures, $26.35 lower PMPM cost.
Population-Based Care Management Framework

1. Well & Low Risk Members (Prevention)
2. Low Risk Members (Prevention and Disease Management)
3. Moderate Risk Members (Disease Management)
4. High Risk, Chronic, Multiple Disease States (Episodic Case Management - Inpatient Clinical Guidelines)
5. Complex Catastrophic Care (Inpatient - LTC) End of Life

Care Management: Target Populations

- 2-3% of Population: Complex Individual Case Management (40% of cost)
- 5-7% of Population: Complex Disease Management – Embedded/Primary Care
- 20-25% of Population: Disease Management – Virtual/Telephonic
- 100% of Population: Wellness/Prevention

Source: Paul H. Keckley, Executive Director, Deloitte Center for Health Solutions, Washington DC PhD, 2007 National Predictive Modeling Summit: The Landscape for Predictive Models
Care Management – Success Stories

• **Swedish Covenant Hospital of Chicago** lowered readmissions of chronically ill patients from 27% to 16%. The aggressive care management effort included 1,800 follow-up phone calls, 175 home visits, and 88% of patients scheduling an appointment with their physician within 14 days of discharge.

• **Princeton Healthcare System** decreased hospitalizations amongst their high risk patients by approximately 30% by increasing immediate post-discharge follow-up to 100%, standardizing patient follow-up appointments to be within 7-14 of discharge, and using IT systems to proactively address concerns.

• **UCSF Medical Center** achieved a 46% decrease (over two years) in 30-day all-cause heart failure readmissions by enhancing patient education, arranging follow-up care, and improving transitions of care amongst their care team.

• **Visiting Nurse Service of NY** reduced hospitalizations by 54%, readmissions by 24%, and ED visits by 27% for frail elderly patients by improving transitional care.

• **Cincinnati Children’s hospital** lengthened time between hospital encounters to 100 days for asthma patients by helping families overcome barriers to effective self-care.

Sources: Commonwealth Fund; HealthIT.gov; Swedish Covenant Hospital

Managing the cost of Post-Acute Care:
Case Example of Episode of Care/Payment for Post-Acute

– **LTACH-$42,500**

– **Inpatient Rehab Facility-$17,500**

– **Skilled Nursing Facility-$11,500**

– **Home Health-$5200**
### Summary of ACO expenditures

<table>
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<tr>
<th></th>
<th>Expense for ACO Assigned Beneficiaries</th>
<th>All MSSP ACOs</th>
<th>Impact of 5% Cost Reduction</th>
<th>Impact of Reaching MSSP Average</th>
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<tr>
<td>Total</td>
<td>$11,494</td>
<td>$9,824</td>
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<td>$3,200</td>
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<td>$891</td>
<td>$692,058</td>
<td>$2,609,422</td>
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<td><strong>Home Health</strong></td>
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<td><strong>$527</strong></td>
<td><strong>$1,012,427</strong></td>
<td><strong>$14,462,779</strong></td>
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Home health alone could generate over 3x the savings as inpatient expenses

**NOTE:** Client example; costs not severity adjusted

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**WHAT’S WORKING AND WHY:**
BUILDING NEW PAYMENT ARRANGEMENTS
## Population Health Market Segments

- Employee Health Plan
- Self-funded Employers
- Private Health Plans
- Medicaid Program
- Medicare Program
- Uninsured
- Retail Health Insurance

## The Medicare Shared Savings Model

![Graph showing projected vs. actual spending with ACO launched at Year 0.](image)

- **Projected spending**
- **Confidence interval**
- **Shared savings**
- **Actual spending**

Source: Lewis, Julie. "What Could be Next for Health Reform? The Debate In Washington" Presentation. The Dartmouth Institute for Health Policy & Clinical Practice. 2009-07-02
**Medicare ACO program**

**Performance year results**

- **Medicare Shared Savings Program**
  - Held spending $652M below targets
  - Earned shared savings over $300M
    - One ACO in Track 2 overspent target by $10M and owed shared losses of $4M
  - Saved Medicare Trust Funds ≈ $345 M
  - Improved on 30 of 33 quality measures
  - Surpassed other Medicare FFS providers’ performance on 17 of the 22 GPRO Web Interface measures

- **Pioneer shared savings:**
  - $96M (saved Medicare Trust Fund ≈ $41M)
  - Showed improvements in 28 of 33 quality measures and experienced average improvements of 14.8% across all quality measures

**MSSP PY1 Financial Results**

- Earned shared savings: 24%
- Generated savings but did not pass MSR: 24%
- Did not generate savings: 52%

**Pioneer PY2 Financial Results**

- Earned shared savings: 13%
- Generated shared losses: 26%
- Did not surpass MSR: 48%
- Deferred reconciliation: 13%

**Medicaid State-based Reform is Accelerating**

- ACOs: 14
- Bundled Payment: 3
- DSRIP: 8

Only Colorado and Oregon have statewide Medicaid ACO models

As of 8/04/2014
**Medicaid ACO Market & Results**

**Colorado’s Accountable Care Collaborative**
- Generated gross savings of $44M, returning $6M to the state after expenses
- Has 350K members (roughly ½ of the state’s Medicaid population),

**Utah’s Medicaid ACOs**
- On track to save the state $2.5B over the next seven years
- Representation of 85% of the state’s Medicaid population

**Oregon’s ACO model**
- Covers 93% of the state’s Medicaid population
- Decreased ED visits by 13% & hospital admissions for chronic conditions by 18% - 36%
- Increase primary care spending by 18%
- Expected to save the state $3.0B over the next 5 years

Source: Electronic Health Reporter, June 10, 2014

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**Major Commercial Health Plan Trends**

- Rapid movement toward consumer driven health plans and new payment arrangements

- Components of new payment models to IDNs/CINs
  - Transformational funding
  - Care management
  - Episodes of Care
  - Shared Savings

- Early adopters include the following
  - Regional Blue Cross plans (MN, MA, IL, HA, etc.)
  - Commercial Health Plans (Aetna, Cigna, Humana, etc.)

- Partnering with MSSP ACOs
  - Universal American (34/28 MSSPs)
  - Walgreens (3)
  - CVS/Caremark (Part D shared savings model)
  - Suppliers (Rx)

- Building delivery systems
  - Highmark purchases seven hospitals/physician practices
  - Cigna – Primary Care Network (PCMH) – Phoenix
  - United Healthcare-Monarch physicians group (2,300 physicians) and Optum
  - Aetna purchases Active Health
  - DaVita acquires Healthcare Partners and other physician groups
Chasing Quality Improvements / Inefficiencies across the continuum

• Bundled payment is a reimbursement model that covers multiple health care services within a specific episode of care for an agreed upon amount (e.g., a target price).

• Goal - to improve patient outcomes while reducing the average cost of episodes.

• Results - Bundled payment has shown the potential for the greatest reduction in health care spending according to a study in the New England Journal of Medicine (NEJM).

Direct Contracting

11% of employers are engaging in some form of direct contracting with employers, while another 28% expect to do so within the next 3-5 years (Aon Hewitt, 2014 p. 33)
Direct Contracting & Commercial Bundles

- Commercial insurers are experimenting with Bundled Payments
- Payors can benefit from a discounted fee arrangement and the chance to partner with a provider willing to work to improve care delivery to the payor’s beneficiaries
- Commercial bundled payment agreements have the potential to increase volume

Jackson Laboratory joined the Maine Health Management Coalition 6 years ago and reported in October of 2014, maintaining flat healthcare cost since 2007, reducing hospitalization by 43% and halving claims above $50,000

Aon Hewitt reports in its “2014 Health Care Survey” that 11% of employers are engaging in some sort of direct health contracting program and that they expect this to increase to 28% in the next 3-5 years
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