Managing Population Health

Developing a Strategic Roadmap for Population Health Management

HFMA, New Jersey Chapter

May 23, 2017
Navigating the Transition Path to Risk

Elements of the Care Transformation Business Model

Attaining Sustainable Population Health
Medicare Shared Savings a Slow Transition to Risk

Overwhelming Majority of ACO Participants Still in Shallow Water

Continuum of Medicare Risk Models

<table>
<thead>
<tr>
<th>MSSP Track 1</th>
<th>MSSP Track 1+</th>
<th>MSSP Track 2</th>
<th>MSSP Track 3</th>
<th>Next Gen ACO</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Upside-only model</td>
<td>• Lowest-risk two-sided model; intended to be attractive to small organizations</td>
<td>• Shared savings, loss rate remains at 60% based on quality performance</td>
<td>• Shared savings up to 75%, shared losses from 40%-75% based on quality performance</td>
<td>• 80%-85% sharing rate or full performance risk</td>
</tr>
<tr>
<td>• Option to renew for second three-year term; savings rate kept at 50% for second term</td>
<td>• Loss rate fixed at 30%; shared savings rate of up to 50%</td>
<td>• Select symmetrical MSR/MLR¹ between 0% and 2% at 0.5% intervals or same methodology as Track 1</td>
<td>• Same MSR/MLR options as Track 2</td>
<td>• Option for capitation</td>
</tr>
<tr>
<td>• MSR based on population size between 2% and 3.9%</td>
<td>• Prospective attribution, SNF 3-day waiver</td>
<td>• Prospective assignment, SNF 3-day waiver</td>
<td>• Prospective attribution; SNF 3-day, telehealth, and post-discharge home visit waivers</td>
<td></td>
</tr>
</tbody>
</table>

<table>
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<th>MSSP Track 3</th>
<th>Next Gen ACO</th>
</tr>
</thead>
<tbody>
<tr>
<td>438 Participants</td>
<td>Available in 2018</td>
<td>36 Participants</td>
<td>45 Participants</td>
<td></td>
</tr>
</tbody>
</table>

¹ Minimum savings rate/minimum loss rate.

### CMS Expanding Downside Risk Options

**Next Generation ACO Model Provides Higher Rewards, New Waivers**

#### Financial Model

- **Prospective benchmark** using one-year baseline historical spending, trended forward using regional factors
- **Risk arrangements** include 80%-85% sharing rate or full performance risk
- **Payment mechanisms** include traditional FFS (with optional infrastructure payments), population-based payments, or capitation

#### Engagement Tools

- **Beneficiary alignment** through prospective attribution and voluntary beneficiary alignment
- **Coordinated care reward** up to $50 annually for beneficiaries receiving at least 50% of care from ACO
- **Benefit enhancements** through payment and program waivers for telehealth, home health, and SNF admission

#### 45 Participants in the Next Generation ACO model

Source: Centers for Medicare and Medicaid Services; Health Care Advisory Board interviews and analysis.
Managing Three Distinct Patient Populations

- **High-Risk Patients**: 5% of patients; usually with complex disease(s), comorbidities
- **Rising-Risk Patients**: 15-35% of patients; may have conditions not under control
- **Low-Risk Patients**: 60-80% of patients; any minor conditions are easily managed

- Trade high-cost services for low-cost management
- Avoid unnecessary higher-acuity, higher-cost spending
- Keep patient healthy, loyal to the system

Source: Health Care Advisory Board interviews and analysis.
Three Common Pitfalls on Care Model Redesign

Three Common Pitfalls

1. Creating a Single Care Model for All
   Targeting all resources to all patients unnecessary, wasteful

2. Segmenting Care by Payer Type
   Risks provider resistance, discomfort; does not allow for appropriate resource allocation

3. Focusing Exclusively on High-risk Patients
   High-risk patient care management a starting point, not the end state

Source: Health Care Advisory Board interviews and analysis.
Difficult to Find One Perfect Care Model

Easy to Mismatch Resources for Differing Patient Types

Arguments Against Population-Wide Enrollment in Medical Home

- **Lack of clinical necessity:** Annual visits not medically necessary for all; high-risk patients in need of case management, not primary care
- **Lack of provider time:** Number of staff, hours in the day not sufficient to accommodate every patient
- **Lack of patient desire:** Many healthy patients do not want the high level of intensive support provided through medical home
- **Lack of sufficient capital:** Medical home visits more costly; model not financially sustainable when applied too widely

Source: Health Care Advisory Board interviews and analysis.
Pitfall #2: Segmenting Care by Payer Type

Population Health Not a Pilot-Specific Strategy

Transformation Requires Organization-Wide Commitment, Investment

The Danger of Too Many Payer-Specific Pilots

- Commercial ACO Pilot
- Medical Home Pilot
- Employer Pilot
- Worksite Wellness Pilot
- Medicaid Behavioral Health Pilot
- Medicare Shared Savings

Efforts are isolated, disconnected from overall system strategy

Limited investment not sufficient for true cultural, organizational transformation

Redesign efforts are temporary, never rolled out on a larger scale

Source: Health Care Advisory Board interviews and analysis.
Pitfall #3: Focusing Exclusively on High-Risk Patients

Limited Financial Impact from High-Risk Alone

Financial Analysis Indicates Necessity of Rising-Risk Patient Management

**Margin by Risk Management Level¹**

<table>
<thead>
<tr>
<th>Year</th>
<th>Baseline (no care management)</th>
<th>+High-Risk Care Management</th>
<th>+High-Risk and Rising-Risk Care Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>(0.7%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>3</td>
<td></td>
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<td></td>
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<td>4</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>5</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

**Model Assumptions**

<table>
<thead>
<tr>
<th>Metric</th>
<th>Initial</th>
<th>After High-Risk Care Management</th>
<th>After High-Risk and Rising-Risk Care Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial cost reduction</td>
<td>0%</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td>Cost growth rate</td>
<td>5%</td>
<td>4%</td>
<td>4%</td>
</tr>
<tr>
<td>Rising-risk moving to high-risk</td>
<td>18%</td>
<td>18%</td>
<td>12%</td>
</tr>
</tbody>
</table>

1) Patient population segmented between high-risk 5%, rising-risk 20%, low-risk 75%.

Source: Health Care Advisory Board interviews and analysis.
The Central Point of Accountability

Care Manager Collaborates with Clinicians to Set Care Plan, Engage Patient

Nurse Care Manager

- RN with 20+ years experience
- Central point of contact for care coordination, patient activation
- RNs may float between clinics lacking sufficient high-risk patient volumes
- RN works with maximum of three clinics

Primary Responsibilities Navigating and Activating Patients Across the Continuum

- Coordinates across sites
- Provides education
- Manages referrals
- Supports patient self-management
- Tracks patient activity
- Encourages frequent communication

Case in Brief: Massachusetts General Hospital, Partners HealthCare

- 900-bed academic medical center based in Boston, Massachusetts
- Part of the six-year CMS Medicare Care Management for High-cost Beneficiaries Demonstration
- Multidisciplinary team provides comprehensive care to top 5% high-risk patients
- Expanded program to serve Pioneer ACO patients, other populations under risk

1) Part of management team that includes Project Manager and Team Leader for Case Management.
2) CMS Demonstration covered top 10% high-risk, high-cost Medicare patients; current top 5% population includes medically complex who would benefit from care management (multimorbid chronic, one severe chronic, mental health/behavioral health/substance abuse, lack of socioeconomic resources to manage illness); excludes medically complex, e.g., complicated obstetrics, trauma.

Bring Care Teams to the Patient’s Home

House Call Program Eliminates Barriers to Appropriate Follow-Up

High-Risk Patient Post-Discharge Care Pathways

Before House Calls Program

Patient too frail to attend follow-up appointment → Patient readmitted to hospital

After House Calls Program

Patient subscribes to house calls program → Patient receives follow-up care in their home

Case in Brief: HealthCare Partners

- 700-physician medical group and 3,900-physician IPA based in Torrance, California
- Launched house calls pilot program in 2011; program employs 2 physicians and 4 NPs who care for 700 high-risk patients
- Services include in-home treatment, x-rays, and labs; as-needed visits from social workers; 24/7 telephonic access

Results of House Calls Pilot Program

11%

Reduction in readmissions

One Care Gap Away From High-Risk

Dangerously Close to High-Risk Spending

The Rising-Risk Escalation Pathway

Home
Patient with diabetes, CHF\(^1\) experiences shortness of breath

Urgent Care
Cost: $140
MD unclear about patient’s medication, administers incorrect dose

Cannot obtain PCP appointment

Cannot obtain PCP appointment

ED
Cost: $1,210
ED physician does not have access to chart, prescribes new medication

Mental status declines

Confused about new regimen

Hospital
Cost: $10,500
Patient hospitalized due to dangerously low blood pressure

Faints

Total avoidable cost of care across urgent care, ED, and hospital

$11,850

Source:
- Elliot VS, “Another Insurer Invests in Urgent Care to Cut Emergency Department Visits,” American Medical News, October 2012;
- Health Care Advisory Board interviews and analysis.

\(^1\) Congestive Heart Failure.
Automated Risk-Stratification for Rising-Risk

Targeting Rising-Risk Patients

Algorithm generates list of 10-20 chronically ill patients who are not meeting treatment goals

Physician reserves one appointment slot per week to meet with staff and review identified patients

Nurse or medical assistant calls patient to communicate physician’s instructions and care plan

Weekly process

Case in Brief: Kaiser Permanente, Northern California

- Nation’s largest not-for-profit health plan based in Oakland, California; serves 3.3 million patients in Northern California
- Tracks chronically ill patients and uses medical records to identify those in need of additional support
- Extended care team reaches out to patients to conserve physician time

Catch Rising-Risk Patients in the ED

ED Case Managers Connect Patients Back to Primary Care

In-the-Moment Education Prevents Returns to the ED

1. ED
   Patient arrives at ED, is registered as FCA\(^1\) patient

2. Warning symbol
   Case manager sees flag in EMR, reviews case details

3. Chart
   Case manager educates inappropriate utilizers

4. Calendar
   When appropriate, primary care visit is scheduled

Case in Brief: UF&Shands

- 1,668-bed academic medical center based in Gainesville and Jacksonville, Florida
- Operates a Medicaid managed care plan (First Coast Advantage) that provides coverage for 75,000 members
- As part of care management efforts for Medicaid population, placed care managers in the ED

ED Case Managers Make Tangible Impact

- 60% Decrease in readmissions to the ED
- 35% → 70% Increase in patients seeing PCP post-discharge

1) First Coast Advantage, UF&Shands managed Medicaid plan.

Source: Health Care Advisory Board interviews and analysis.
Keep Patients Healthy and Loyal to the Network

Low-Risk Patient Care Utilization
- Limited health system interaction
- Do not see primary care physician on an annual basis; may lack a designated PCP altogether
- Prefer to interface with the health system via virtual access points
- Desire easy access to health information when necessary

Making the Economics Work
1. Limit PMPM\(^1\) spend on key services
2. Keep patients loyal to your health system
3. Maintain patients in your network from year-to-year

Low-Risk Patients: 65-80% of patients
Healthy patients; may have one well-managed chronic condition

High-Risk Patients
Rising-Risk Patients
Low-Risk Patients

Source: Health Care Advisory Board interviews and analysis.

1) Per member, per month.
Portals an Engagement, Loyalty Driver for All Patients

Not Just for Millennials

**Portal Key Features**
- Communicate with physician
- Assign proxy access
- View medical record
- Fill prescriptions
- Manage health benefits
- Schedule appointments

**Age Distribution of Patients Using Kaiser’s Patient Portal**

Case in Brief: Kaiser Permanente Northern California
- Nation’s largest not-for-profit health plan based in Oakland, California; serves 9 million members nationwide, 3.3 million in Northern California
- Began offering online health services in 1996; fully deployed KP.org patient portal in 2007

Navigating the Transition Path to Risk

Elements of the Care Transformation Business Model

Attaining Sustainable Population Health
What Makes for a Comprehensive Network?

 Depends on the Target Market for Risk-Based Populations

Many Different Options for Network Scope

Local
- Small employers
- Local payers

Regional
- Large employers
- National payers

Super-Regional
- State/national employers
- International purchasers

What is your organization’s network assembly strategy?

Source: Health Care Advisory Board interviews and analysis.
Network Assembly At Every Level

Partners, Business Units, Network are Key Components

Three Dimensions of Network Scope

1. **Build targeted, low-cost network**
   - Network must address market needs at the system level
   - *System partnerships*

2. **Realign business strategy to meet population health goals**
   - Investments must reflect population health agenda
   - *Business units*

3. **Refine preferred partner network**
   - Business must be directed to top performers to reduce cost of care
   - *Provider network*

Source: Health Care Advisory Board interviews and analysis.
Addressing Individual Limits in Geographic Reach

Partnering to Expand Geographic Scope

- Cincinnati-based employers have employees living on both sides of river
- Joint venture collaboration between Cincinnati, Ohio-based TriHealth and Edgewood, Kentucky-based St. Elizabeth Healthcare
- Offers health insurers access to a unified, high-quality, low-cost network that covers the entire Tristate region
- Both organizations offering the network to their current employees and dependents

Neither Organization Able to Offer Adequate Geographic Coverage Alone
**Developing a Targeted Network Strategy**

Flexible Approach Meets the Demands of a Wide Range of Purchasers

**A Multi-Layered Approach to Network Development**

<table>
<thead>
<tr>
<th>Geographic Reach</th>
<th>Number of Contracting Possibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Local</strong></td>
<td></td>
</tr>
<tr>
<td>Individual footprint sufficient to appeal to small employers in local market</td>
<td></td>
</tr>
<tr>
<td><strong>Regional</strong></td>
<td></td>
</tr>
<tr>
<td>Partnership with like-minded, geographically contiguous health system provides flexibility to sign larger regional contracts</td>
<td></td>
</tr>
<tr>
<td><strong>Super-Regional</strong></td>
<td></td>
</tr>
<tr>
<td>Discussing possibility of additional partnerships to form state-wide network able to contract with state employers</td>
<td></td>
</tr>
</tbody>
</table>

**Network in Brief: Geiss Health¹**

- Integrated health delivery system in the Midwest
- Segments network by geography
- Health system footprint is sufficient for appealing to local purchasers; regional and super-regional networks assembled through partnership

1) Pseudonym.

Source: Health Care Advisory Board interviews and analysis.
Promise of Increased Referrals Creates Performance Incentive for PACs

Preferred Partner Criteria

- Ability to start IV lines 24/7
- Quality rating of three to five stars
- Able to admit patients within two hours
- Nurses on-site 24/7

Reducing Hospitalizations at OSF’s Preferred Network

Heart Failure Re-hospitalization Rate

- 6% in 2010
- 2% in 2012

All-Cause Readmission Rate

- 13% in 2010
- 7.5% in 2012

Case in Brief: OSF Healthcare

- Eight-hospital, not-for-profit health system based in Peoria, Illinois
- As part of its Pioneer ACO strategy, created a preferred SNF network limited to 17 facilities who met target criteria

Reach Common SNF Standards Streamlines Care

Partner with Area Providers to Establish Consistent Requirements

Conflicting Requirements

Different standards from each ACO inhibited implementation and operative partnership

Resolve with Standards

One set of common standards from all ACOs allows SNF to act effectively

Case in Brief: Steward Health Care Network

- 2,800-physician network for hospitals of Steward Health Care System, headquartered in Massachusetts
- Partnered with four other ACOs in market to create standards for SNFs

For full list of standards, please see appendix.

Source: Health Care Advisory Board interviews and analysis.
Realign business strategy to meet population health goals

**In Medium Term, Change Investment Strategy**

Changes in Utilization Allow for Shift in Fixed Assets

**Ensure Capital Allocation Matches Population Health Goals**

**Tailored, Low-Cost Network**

- Establish comprehensive partner network appropriate sized to market
- Partnership results in reduced utilization, lowered costs

**Strategic Plans**
- Build population health and network management into business unit oversight

**Infrastructure Investments**
- Shift bricks and mortar investment strategy to appropriate scope of patient care

Source: Health Care Advisory Board interviews and analysis.
Reinforce Population Health through Budget Process

Committee Ensures Alignment of Capital Proposals

From Maximizing Volume to Population Health

1. Capital budget proposals submitted
2. System-wide committee review
3. Population health prioritized in budget process

Case in Brief: Intermountain Healthcare

- 22-hospital health system based in Salt Lake City, Utah
- Currently in third year of having committee review capital budget proposals for alignment with population health goals

Committee Existence Drives Language Shift

“It’s no longer ‘we need to buy these machines to meet the volume demand,’ but instead we focus on understanding the volume of care that is indicated by evidence and buying the equipment to meet that need.”

Joe Mott, VP of Healthcare Transformation

Source: Health Care Advisory Board interviews and analysis.
Infrastructure investment

Shift Bricks and Mortar Investment Strategy

Staging Shift in Physical Asset Planning

- **Repurpose Existing Spaces**
  - Revamp acute care investments to better align with population health strategy

- **Add Necessary Services**
  - Invest in service offerings, such as behavioral health, that support care management goals

- **Rightsize Hospital Capacity**
  - Ensure inpatient capacity closely matches long-term utilization trends

Source: Health Care Advisory Board interviews and analysis
New Priorities Necessary Under Population Health

Aligning Network to Promote Low Unit-Cost and Trend Control

Heard in the Research

“Deprioritizing…”
- Excess inpatient capacity
- Free-standing imaging
- High-end clinical technology
- Ambulatory surgery centers

“Investing In…”
- Primary care/care management
- Urgent care/retail spaces
- Behavioral health
- Telemedicine

Source: Health Care Advisory Board interviews and analysis.
Map Inpatient Capacity to Population Health Goals

Repurpose Existing Acute Care Spaces

Convert Inpatient Beds to Multipurpose Spaces

Inpatient bed utilization declines under population health management

Converted spaces available for multidisciplinary care team use

Case in Brief: Mosaic Life Care

- Regional medical center based in St. Joseph, Missouri
- Turned inpatient beds into multipurpose spaces after entering into risk-based contracts, declines in ambulatory sensitive admissions

Source: Health Care Advisory Board interviews and analysis.
Invest In Services Essential for Care Management

Additional Behavioral Health Beds Vital to Controlling Population Costs

Necessity of Behavioral Health Under Different Payment Models

**Fee-for-Service**
- **Limited interest:** Behavioral health typically unfavorably reimbursed

**Value-Based**
- **Necessity:** Important to coordinate clinical and behavioral needs across all care settings

Supporting Behavioral Health

- **40** Inpatient beds added in past 9 months
- **21%** Total increase in Steward behavioral health beds
- **60%** Average increase in per capita costs for Medicaid patients with behavioral health need

Case in Brief: Steward Health Care Network

- 2,800-physician network for hospitals of Steward Health Care System, headquartered in Massachusetts
- Increased investment in behavioral health to better support population health efforts

Growth in Covered Lives Critical to ROI

But Many Potential Stumbling Blocks Along the Way

**Benefits of Covered Life Growth**
- Improved actuarial stability
- Reduced per-unit care management costs
- Aligned organizational priorities
- Increased physician engagement

**Potential Obstacles to Growth**
- Lack of payer trust
- Limited strategic alignment within organization
- Slow uptick of new contracts
- Lack of clarity on internal organizational strengths

Source: Health Care Advisory Board interviews and analysis.
Pushing Past the Pilot Mentality

Growing Number of Lives Under Management

Typical PCP\(^1\) Patient Panel

Patients currently covered by population health pilots

Number of lives necessary under population health contracts to meaningfully change practice patterns

Fundamentals of Population Health Growth Strategy

- **A** Map initial patient population growth to core competencies
- **B** Identify complementary expansions to core competencies to gain new lives
- **C** Weigh integration of delivery, financing systems

1) Primary care physician.

Source: Health Care Advisory Board interviews and analysis.
Begin with Internal Areas of Expertise

Growth Strategy Focused on Core Competencies

Three Key Attributes for Growing Managed Populations

**Care Management**
- Expertise caring for high-risk, high-utilizers with comprehensive infrastructure of care managers
- Scaled infrastructure with medical home for rising-risk patients

**Network Management**
- Ability to coordinate care across providers
- Breadth and depth of specialist, post-acute care

**Patient Engagement**
- Ability to partner with patients to encourage self-management
- Drive patient loyalty to health system

Source: Health Care Advisory Board interviews and analysis.
Building on Existing Care Management Expertise

Montefiore Bringing Care Management Expertise and Infrastructure to Additional Populations

Highly-Centralized Care Management Infrastructure

- Disease management
- Patient education
- Care coordination across settings

- Complex care management programs
- Intensive case management
- Community partnerships

Current Population Under Management

- Includes low-income, high-risk
- Complex socio-economic profile
- Covered by commercial, Medicaid, Medicare

Expansion population

- Geographically-contiguous population
- Attributes quite similar to population currently under management
- Easily managed by existing infrastructure

Case in Brief: Montefiore Medical Center

- 2,200-bed health system based in Bronx, New York
- CMO, Montefiore’s care management company, oversees value based arrangements covering 300,000 individuals
- 800 employees support care management enterprise
- Existing population under management represents broad mix of commercial, Medicaid and Medicare
- Expanding care management services into new geographically-contiguous markets

Source: Health Care Advisory Board interviews and analysis.
B) Network management

Aligning Growth with Operational, Clinical Resources

Map Population Expansion to Existing Infrastructure

Steward Maps Growth to Four Network Assets

- **Primary Care Network**
  Large, comprehensive primary care group provides foundation for populations under risk

- **Care Management Programs**
  Extensive care management infrastructure supports primary care

- **Specialist Network**
  Existing specialist network extended by partnerships when necessary

- **Inpatient Service Lines**
  Broad inpatient service lines tightly integrated with population health resources, infrastructure

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**Case in Brief: Steward Health Care Network**

- 2,800-physician network for hospitals of Steward Health Care System headquartered in Massachusetts
- Steward considers four key network components when determining whether it has the level of infrastructure and resources to effectively support the population for which it will take on risk
- Focusing growth on populations that fit into existing operational and clinical infrastructure

Source: Health Care Advisory Board interviews and analysis.
Expand Successful Worksite Programs

Effective Employee Management Demonstrates Proof of Concept

Froedtert’s Online Success Stories Highlight Program Achievements

City of Milwaukee Health Risk Assessment

- The City cited a 14% decrease in employee share of health costs for 2013, noting its wellness program and targeted disease management among contributing factors
- 87% of participating employees rated Workforce Health as “excellent” for their professionalism
- 98% of participants said the education given to them was tailored to their personal needs

Case In Brief: Froedtert & the Medical College of Wisconsin

- Three-hospital health system located in Milwaukee, Wisconsin
- Created a “Success Stories” page on the Froedtert Workforce Health website featuring case studies of successful partnerships
- Highlights these stories in conversations with potential employers and directs them to the website for more detailed information
# Organization Strengths Determine Target Population

## Importance of Population Health Competencies, by Insurance Product and Population Risk Stratification

<table>
<thead>
<tr>
<th></th>
<th>Care Management</th>
<th>Network Management</th>
<th>Patient Engagement</th>
<th>Target Population</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HMO</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High risk</td>
<td>●</td>
<td></td>
<td>●</td>
<td>Medicare Advantage Medicare Advantage</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Medicaid Managed Care</td>
</tr>
<tr>
<td>Rising risk</td>
<td>●</td>
<td>●</td>
<td></td>
<td>Medicare Advantage Commercial/Employer</td>
</tr>
<tr>
<td>Low risk</td>
<td>●</td>
<td>●</td>
<td></td>
<td>Commercial/Employer</td>
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<tr>
<td><strong>PPO</strong></td>
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<td>●</td>
<td></td>
<td>Commercial/Employer</td>
</tr>
</tbody>
</table>

- **Very High Importance**
- **High Importance**
- **Medium Importance**
- **Low Importance**

Source: Health Care Advisory Board interviews and analysis.
# Identifying the Elements of Sustainable Contracts

## Five Core Attributes of Best-in-Class Value-Based Contracts

<table>
<thead>
<tr>
<th>Feasibility</th>
<th>Appeal</th>
<th>Sustainability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Should we consider taking on this contract?</td>
<td>How can we make this contract align to population health initiatives?</td>
<td>How do we operationalize the contract?</td>
</tr>
<tr>
<td>1 Prioritize narrow network product design</td>
<td>3 Secure upfront financing for population health infrastructure</td>
<td>5 Negotiate to increase frequency of claims feed</td>
</tr>
<tr>
<td>2 Develop customized, market-specific cost targets</td>
<td>4 Standardize quality metrics around internal areas of focus</td>
<td></td>
</tr>
</tbody>
</table>

Source: Health Care Advisory Board interviews and analysis.
Identify Non-negotiable Contract Elements

Knowing What to Insist On, What to Negotiate the First Step

Elements of Crystal Run’s Ideal Contract

**Patient Attribution**
- Physician roster
- Methodology
- Panel update frequency

**Cost of Care**
- Benchmarks
- Expenditure calculations
- Sharing rates, mechanism

**Quality**
- Number, type of metrics
- Target methodology
- Reporting requirements

**Data**
- Monthly attribution updates
- Claims data feed requirements
- Quality performance updates

Case in Brief: Crystal Run Healthcare

- 300-physician multi-specialty group based in Middletown, New York
- Participating in the MSSP, commercial risk-based contracts
- Created template for what the organization seeks in commercial risk-based contracts
- Enters negotiations with health plans having identified the configuration of elements that are ideal for Crystal Run Healthcare

Source: Health Care Advisory Board interviews and analysis.
## Defined Networks Require Active Patient Selection

### Patients Choosing Narrow Networks Have Lower Leakage Rates

#### Selecting Network Reduces Leakage

<table>
<thead>
<tr>
<th><strong>Pioneer Program</strong></th>
<th><strong>Network Leakage Rates</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>- Open access network; patients not required to choose PCP</td>
<td><strong>Pioneer ACO Program</strong></td>
</tr>
<tr>
<td>- Patients may not realize they’re covered by Parcell(^1) network, may have deliberately chosen open access network</td>
<td>40%</td>
</tr>
</tbody>
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<tr>
<th><strong>Medicare Advantage</strong></th>
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<td>- Narrow network; patients enrolled in MA(^2) contracts for Parcell network required to choose Parcell PCP</td>
<td>5%</td>
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<tr>
<td>- Patients choose to enroll in MA plan, likely more activated, understand they signed up for narrow network</td>
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### Case in Brief: Parcell Physician Group\(^1\)

- Large physician group in the East
- Participated in the Pioneer program, also takes risk through MA\(^2\) contracts
- Patients covered by MA contracts choose physicians, sign up for Parcell MA network
- Found lower leakage rates for MA patients than Pioneer patients, signals more care sought in the Parcell network

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1) Pseudonym.
2) Medicare Advantage.

Source: Health Care Advisory Board interviews and analysis.
Incent the “Right Utilization” through Benefit Design

Covenant Health’s Benefit Pricing Strategy

- Increasing Service Price
  - ED visits
  - Urgent care visits
- Decreasing Service Price
  - Generic prescriptions
  - Primary care visits (free)

Benefit Design Levers to Inflect Utilization Patterns

1. Change Price of Services, Products
   *Strategies to Consider:*
   - Differentiate network prices
   - Raise emergency department copays
   - Tier pharmaceutical price structure
   - Reduce price of preventive services

2. Limit Access to Certain Services, Products
   *Strategies to Consider:*
   - Remove certain brand-name pharmaceuticals from formulary
   - Require prior authorizations for imaging services

Case in Brief: Covenant Health

- Three-hospital health system based in Lubbock, Texas
- Already at risk for own employees
- Using employees’ health plan benefit design to encourage appropriate utilization of primary care, generic prescriptions to reduce costs

Source: Health Care Advisory Board interviews and analysis.
Knowing Who to Target Half the Battle

Upfront Patient Assignment, Notification Helps Solve Attribution, Leakage

Patients Required to Choose Primary Care Clinic in Broad Network

Case in Brief: Rossitano Clinic

- Large multi-specialty physician group based in the West
- Partnering with commercial health plan on open access PPO product through which any patient that picks the product is required to choose a primary care clinic for assignment
- Provider will receive notification from health plan when patient chooses Rossitano Clinic, also when a patient switches providers
- Rossitano Clinic is better able to target care management services to patients assigned under the arrangement with health plan

1) Pseudonym.
2) Preferred provider organization.

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Source: Health Care Advisory Board interviews and analysis.
Cost Targets Should Reflect Institutional Priorities

Attributes of Favorable Expenditure Targets

**Customized**
Target must be attainable and appropriate to organizations’ unique circumstances

**Defined Up-Front**
Organization must know the expenditure target prior to the performance period

**Risk-Adjusted**
Target reflects attributed population’s aggregated risk

Three Commonly Used Methodologies

1. **Comparison against “percent of premium”**
   - Health plan defines a percent of premium dollars collected from attributed population as target expenditure
   - At end of performance period, total actual expenditures compared to target expenditure

2. **Comparison against local, network benchmark**
   - Health plan determines benchmark, cost growth target for provider’s market, rest of health plan network
   - At end of performance period, provider’s results compared against the market’s, network’s benchmark

3. **Comparison against historical baseline**
   - Health plan aggregates provider’s historical spend for attributed population, trends historical expenditures to identify target
   - Provider’s actual expenditures compared to target at end of performance period

Source: Health Care Advisory Board interviews and analysis.
Attracting Bridge Financing to Get Started

Incenting Success by Placing Support at Risk

Process for Prospective Quality Payments at Spurlock Health

$ Health plan pays out PMPQ\textsuperscript{2} care coordination fees at beginning of quarter

First Quarter

Spurlock Health uses funds to hire care coordinators, improve disease registry

- Spurlock Health achieves all quality metrics during quarter
- Keeps entire care coordination fee payment

- Spurlock Health does not achieve all quality metrics
- Required to pay back PMPQ received for each metric missed

Case in Brief: Spurlock Health

- Large health system located in the West
- Care coordination fees paid by health plan at beginning of each quarter, receives $1 PMPQ\textsuperscript{2} for each quality metric included in contract, up to $8 total PMPQ
- Spurlock must pay back fees received for any metrics missed at end of performance period
- Funds investments necessary for success under population health contracts

\textsuperscript{1)} Pseudonym.
\textsuperscript{2)} Per-member, per quarter.

Source: Health Care Advisory Board interviews and analysis.
Facing an Overwhelming Number of Quality Metrics

Sheer Number, Variation of Metrics Makes Targets Difficult to Hit

Two Considerations When Standardizing Quality Metrics

1. Which metrics should we choose to standardize around?
   - Metrics commonly standardized around nationally-accepted performance benchmarks (e.g., HEDIS\(^1\) or CMS ACO measures)
   - Insist on standardization around quality metrics that are already a priority

2. How do we standardize quality metrics across population health contracts?
   - Different metrics across contracts, with some organizations tracking more than 100 metrics across all of their population health contracts
   - Focus on subset of metrics with a halo effect to entire metric list

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1) Healthcare Effectiveness Data and Information Set.
Prioritize Metrics that Already Require Focus

- Participation in MSSP requires that Covenant Health focus on 33 MSSP quality measures

- Covenant Health enters commercial contract negotiations with list of MSSP quality measures
  - Asks health plans to choose 6-8 quality measures from the MSSP list to include in contract

**Case in Brief: Covenant Health**

- Three-hospital health system based in Lubbock, Texas
- Participating in MSSP, negotiating risk-based contracts with commercial health plans
- Goal is to have six to eight quality metrics included in each commercial contract
- Already required to focus on MSSP quality measures, asking health plans to choose six to eight metrics from that list to include in contracts

1) Medicare Shared Savings Program.

Source: Health Care Advisory Board interviews and analysis.
Case in Brief: Summit Medical Group

- 220-physician primary care group based in Knoxville, Tennessee
- Participating in risk contracts through MSSP, with MA¹, commercial health plans, with each contract including different quality measures to track
- Prioritized improvement on 14 metrics with significant impact on patient care and quality performance

Source: Health Care Advisory Board interviews and analysis.

¹) Medicare Advantage.
Employ Dedicated Staff to Manage Quality Metrics

Twin Strategies for Managing Quality Metrics

Population Health Advocates
Target the individual contract-stipulated quality metrics to ensure performance

Quality Scorecards
Created to track the quality metrics included in each risk-based contract Crystal Run participates in

Case in Brief: Crystal Run Healthcare

- 300-physician multi-specialty group based in Middletown, New York
- Tracking 108 quality measures across all risk-based contracts
- Employs “population health advocates” (PHAs) as part of administrative staff to target performance on quality measures
- PHAs use internally-created quality scorecards for each payer to ensure that Crystal Run achieves each quality metric for that contract

Source: Health Care Advisory Board interviews and analysis.
Road Map

1. Navigating a Rocky Transition Path

2. Elements of the Care Transformation Business Model

3. Attaining Sustainable Population Health
Creating a Virtuous Cycle of Growth

Attaining Financial Returns from Care Transformation

Total Cost of Care

Assemble the Low-Cost Network

Identify and Secure New Lives for Management

Successful business model facilitates new growth

Operate Performance-Based Care Network

Building the Network

Acquiring Lives and Managing Care
Engagement a Hidden, But Crucial, Renewal Lever

Consumerism, Population Health Strategies Converge

Winning at Point of Network Selection

Successful Population Health Management → Lower Total Cost → Lower Premium → Network Selection

Experience → Engagement

Source: Health Care Advisory Board interviews and analysis.