The Cost of Care: Understanding the Next Generation of Payment Models

Presented by:
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Sisters of Charity Health System and Exempla Healthcare
October 11, 2012
Today’s Objectives

- Understand future health care payment models
  - *Overview of history and explanation of current*
- Readiness and infrastructure for changing reimbursement models.
  - *Continuum of Care*
- Exempla Case Study
  - *ACE* (Acute Care Episode)
    - Pioneer ACO
    - Capitation in Cardiology Services
    - Commercial Payer Partnerships
- Next Step
Who are We: Where We Serve

St. James Healthcare
Butte, MT

St. Vincent Healthcare
Billings, MT

Holy Rosary Healthcare
Miles City, MT

Saint John Hospital
Saint Vincent Clinic
Leavenworth, KS

Duchesne Clinic
Kansas City, KS

Providence Medical Center

St. Francis Health Center
Marian Clinic
Topeka, KS

Holton Community Hospital
Holton, KS

Saint John’s Health Center
Santa Monica, CA

St. Mary’s Hospital & Regional Medical Center
Marillac Clinic
Grand Junction, CO

Exempla Good Samaritan Medical Center
Lafayette, CO

Exempla Lutheran Medical Center
Wheat Ridge, CO

Exempla Saint Joseph Hospital
Mount Saint Vincent Home
Denver, CO

- Hospitals and clinics for the uninsured owned by SCLHS
- Hospitals Affiliated with SCLHS
Motivators and Drivers

for Change

• Poor quality documented
• Unsustainable increases in health care costs and over utilization
  – Deficit
  – Under estimated the costs of PPACA
• Rewarding the production of volume with no improvement in outcomes
• Provider integration
• What else???
Payer Dynamics

Medicare: Paying for Health Reform

“The Good Old Days”

Spending for Health Reform = $938 Billion

Paying for Health Reform = $1,081 Trillion

Source: CBO Letter to Nancy Pelosi, March 20, 2010; Joint Committee on Taxation Report JCX-16-10, March 20, 2010; PwC Analysis
Payment Models: What are Payers/Purchasers talking about…

- **Bundled payments**
  - CMMI (Center for Medicare & Medicaid Innovation)
  - ACE
  - Prometheus

- **Shared Savings**
  - Pioneer Program
  - ACO Medicare Shared Savings (MSSP)

- **Global Payment**
  - Capitation

- **Medical Homes**
  - Management fee - Per member per month (anywhere from $1 to $7 pmpm)

- **Health Exchanges**
  - Buying on price and quality
Pursuit of Risk Contracts Typically Not Making the Cut

2010

- Conclusion of Physician Group Practice Demonstration initial period
- Acute Care Episode (ACE Demonstration Begins)

2011

- December 2011: 32 organizations selected for Pioneer Shared Savings Program

2012

- April 2012: 27 organizations selected for CMS Shared Savings Program
- March 2012: Final proposals due to CMMI Bundled Payment Pilot
- July 2012: 89 additional organizations selected for CMS Shared Savings Program
- Aetna forms ACO
- Cigna and Palo Alto Medical form ACO
- BCBSNC forms ACO
- HR 2012: Models 2-4 of CMMI pilot to begin
There is expected to be ~750 ACOs in the U.S. by 2016, the majority of which will be in the Operate phase.

Annual Number of ACOs by ACO Formation Phase (2011-16F)

Number of ACOs

<table>
<thead>
<tr>
<th>Year</th>
<th>Exploratory</th>
<th>Design</th>
<th>Build</th>
<th>Pilot</th>
<th>Operate</th>
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<td>302</td>
<td>26%</td>
<td>18%</td>
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<td>2012F</td>
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<td>730</td>
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<td>2016F</td>
<td>747</td>
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<td>5%</td>
<td>10%</td>
<td>74%</td>
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Source: L.E.K. Analysis
Required Integration Between CFO and Clinicians Can Cause Discomfort

“High Stake Gamblers”

Success Requires Proper Balance of Care Transformation and Contractual Risk

Too ahead of the curve

Accountable Payment at Risk

Care Transformation

Capitation

Shared Savings

Episode-based Bundling

Medicare Claw Back

P4P
Strategic Imperative

Moving Upstream
Re-envisioning the Health System Strategy

Health systems seeking to control the premium dollar...

Inpatient 18%
Outpatient 22%
Physician 24%
Rx 16%
Other Medical 5%
Health Plan Admin 14%

...and steer volume back to owned assets

Benefits of Moving Upstream

- Steerage and Strategic Network Expansion
- Control of Information and Data
- Incentive Dollars to Physicians
- Lower Revenue Cycle Friction
- Strategic Leverage, Option Value
- Higher Margin Business Model

UPMC Operating Results

- Inpatient EBITDA $152M (19% of total)
- Non-Inpatient EBITDA $513M (64% of total)
- Health Plan EBITDA $136M (17% of total)

≈ TOTAL EBITDA $801M
Essential Provider Competencies For Risk & Gain Sharing

1. Governance and Leadership
2. Physician Engagement
3. Information Technology
4. Clinical Performance Management
5. Population Health Management
### Current Reform Landscape: P4P Timeline

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<td>10%</td>
<td>10%</td>
<td>10%</td>
<td>8%</td>
<td>8%</td>
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% = % of Medicare Inpatient Operating Payments

*The Multifactor Productivity Adjustment is an estimate generated by the CMS Office of the Actuary
**DCA, also known as the behavioral offset, shown here does not show the future affects of these cuts on baseline spending
***If Congress has not adopted the Joint Committee's report to reduce the deficit by at least $1.2 trillion, the 2% cut will be implemented January 2013
The Value Equation

- In health care, measuring value remains elusive

**Value** = Quality in relation to total payment for care

- Quality = a composite of patient outcome, safety and experiences
- Total payment = the cost to all purchasers of purchasing care (employers, insurers, government and patients)
- Total payment considers the volume of care as well as cost per care provided
Payment Models
CMI Bundled Payment Program

what........

CMS is seeking to **partner with organizations** that are focused on the transformation of their payment and care delivery model from one reliant on FFS volume to one that is more focused on optimizing outcomes of care.

All models are expected to include **care redesign** and enhancements such as reengineered care pathways using evidence-based medicine, standardized care using checklists, and care coordination.

All may also include **opportunities for gainsharing** among participating providers. Under all models, applicants must provide Medicare with a discount on Medicare FFS expenditures.
Episode of care or Bundling

*What is it* ............... 

Providers assume financial and quality performance risk for:

- All services for a particular treatment or condition:
  - physician, lab, Imaging, DME
  - Acute Care/hospital
  - All post acute care related to the condition including Medicare SNF rehabilitation costs
- Avoidable complications and mortality
- All readmission costs
CMS: ACO Shared Savings
Final Rule 10/11

- Patient Assignment
  - Prospective vs. retrospective
- Payment Structure
  - Shared savings
- Quality Measures
- Electronic health record
- Graduated risk
Global Capitation

(Ultimate Risk)

• At risk for providing and paying all medical costs; inpatient, outpatient, RX….etc.

• Per member per month (PMPM)
  – Commercial = $4,000 pmpy
  – Medicare = 13,450 pmpy
  – Medicaid
    • $2,500 pmpy kids
    • Nursing Homes = $6 pmpy

• This is not the premium

\[ P = \text{total medical costs} + \text{health plan} + \text{profits} \]
# Exempla Healthcare

## Payer Contracts with Quality Provisions

<table>
<thead>
<tr>
<th>PAYOR</th>
<th>TYPE</th>
<th>TIME FRAME</th>
<th>STRATEGY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anthem</td>
<td>IP</td>
<td>2011</td>
<td>1% directive, administrative data</td>
</tr>
<tr>
<td>Cigna</td>
<td>IP/OP</td>
<td>2012</td>
<td>House account - 6,000 lives; steerage, cost reduction, quality improvement, payment reform, Prometheus</td>
</tr>
<tr>
<td>ACE Demonstration</td>
<td>Bundled</td>
<td>2012</td>
<td>Expansion of ACE to post acute – CMI</td>
</tr>
<tr>
<td>Kaiser Permanente</td>
<td>IP</td>
<td>2011</td>
<td>Partnership, volume with critical mass</td>
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# September 2011 Report Card

## Exempla - Kaiser Joint Report Card - Year-to-date Values

<table>
<thead>
<tr>
<th>Clinical Quality</th>
<th>BITN</th>
<th>ESJH</th>
<th>EGSMC</th>
<th>Reporting Period</th>
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<tbody>
<tr>
<td>AMI Mortality (30-Day)</td>
<td>0.58</td>
<td>0.28</td>
<td>0.00</td>
<td>Jun-11 YTD</td>
</tr>
<tr>
<td>Acute Myocardial Infarction (AMI) Appropriate Care Score</td>
<td>98.8%</td>
<td>94.7%</td>
<td>97.5%</td>
<td>Jun-11 YTD</td>
</tr>
<tr>
<td>AMI 30-day Readmissions (# patients) **</td>
<td>0.57</td>
<td>0.37</td>
<td>(3)</td>
<td>Jun-11 YTD</td>
</tr>
<tr>
<td>Heart Failure (HF) Appropriate Care Score</td>
<td>97.9%</td>
<td>94.9%</td>
<td>87.5%</td>
<td>Jun-11 YTD</td>
</tr>
<tr>
<td>Heart Failure 30-day Readmissions (# patients) **</td>
<td>0.59</td>
<td>0.61</td>
<td>(22)</td>
<td>Jun-11 YTD</td>
</tr>
<tr>
<td>Pneumonia (PN) Appropriate Care Score</td>
<td>95.3%</td>
<td>96.8%</td>
<td>89.0%</td>
<td>Jun-11 YTD</td>
</tr>
<tr>
<td>Pneumonia 30-Day Readmissions</td>
<td>0.58</td>
<td>0.49</td>
<td>(3)</td>
<td>Jun-11 YTD</td>
</tr>
<tr>
<td>Surgical Care Improvement Project (SCIP) Appropriate Care Score</td>
<td>95.5%</td>
<td>92.3%</td>
<td>87.3%</td>
<td>Jun-11 YTD</td>
</tr>
<tr>
<td>Sepsis Mortality (%) **</td>
<td>TBD</td>
<td>6.8%</td>
<td>7.8%</td>
<td>Aug-11 YTD</td>
</tr>
<tr>
<td>Falls with Injury (NQFQ definition) (# patients)</td>
<td>0.00</td>
<td>0.99</td>
<td>(48)</td>
<td>Aug-11 YTD</td>
</tr>
<tr>
<td>OB Services: C-Section Rate</td>
<td>TBD - baseline</td>
<td>22.6%</td>
<td>28.0%</td>
<td>Jul-11 YTD</td>
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<tr>
<td>OB Services: VBAC Rate</td>
<td>TBD - baseline</td>
<td>27.0%</td>
<td>18.0%</td>
<td>Jul-11 YTD</td>
</tr>
</tbody>
</table>

## Patient Safety

| Pressure Ulcers (SRE definition - per 1000 admissions) (#) ** | 0.84  | 0.15  | (2)   | (2)  | Aug-11 YTD      |
| Postoperative PE or DVT (PSI 12 - per 1000 patients at risk) (# patients) | 0.0   | 5.8   | (18)  | 4.4  | (7)  | Jun-11 YTD      |

## Best Teams

| AHRQ - Patient Safety Culture Survey (% positive score) | 64.1% | 41.1% | 59%   | Jul-11 YTD      |

## Service Performance

| HCAHPS: Overall Rating of Hospital (% in top 2 box) ** | 74.7% | 69.1% | 75.3% | Jul-11 YTD      |
Performance Results

Sepsis Mortality
4.4% decrease in hospital Sepsis mortality across Exempla Healthcare based on early identification and order set use

95 Additional Lives are projected to be saved by end of year from these interventions
ACE Demonstration

Purpose

“To determine whether improvements in quality of care can result from the alignment of financial incentives between hospitals and physicians, in such a way that they must coordinate care on a case-by-case basis.”
CMS ACE
Flow of Funds…….
Physician engagement:

- Improve quality of care
- Financial opportunities
  - Receive gain-sharing up to 125% RBRVS – CMMI is 150% RBRVS
  - 100% of Medicare Allowable (no collections from patients)
PHO and TPA Functions

- Requires PHO – can be formed just for the project
  - Physician agreements
    - documentary evidence of an agreement between the entities
  - Clinical protocols
  - Gainsharing arrangements
- Signed statement agreeing to the accepting site’s own bundled-payment amounts
- Shows evidence of a quality committee between hospital and board-certified physician representatives
Gainsharing Protocol

Physician-Incentive Methodology

- **Step 1 – Definitions**
  - Determine baseline for quality, utilization, and direct costs
  - Measurement quarters: four quarters in given year
  - DRG groupings
  - Patient populations – Medicare inpatients in fee-for-service program with Part A and B

- **Step 2 – Quality Validation**
  - Payment begins with key parameter of quality. Physicians who fail to meet will not be eligible
  - Physician payments capped at 125% of RBRVS
Gainsharing Protocol (cont’d)

- **Step 3 - Savings**
  - Calculate by collecting the physician’s actual billing records for patients included in the program
  - Determine if the overall costs of the specific DRG decreased – every DRG will have a baseline
  - Can have no increases in other areas – no new costs

- **Step 4 - Payment**
  - Apply adjustments to savings in initiative
  - Payment capped based on difference between baseline and weighted average costs for all participating physicians
  - Payments are allocated on physician’s or group’s volume and practice pattern
  - Calculate payments within 90 days of calendar quarter end. Payments are not cumulative, and start anew each quarter
Physician-Incentive Examples

- **Mechanical Value**
  - All physicians’ baseline average unit costs = $6,000
  - Physician A Q1 average unit cost = $5,000
  - Physician A Q1 value volume = 10
  - Physician A Q1 savings = ($6,000-$5,000) x 10 valves = $10,000

- **Open heart surgery treatment delays – start-time reduction**
  - All physicians’ baseline average = 45 minutes
  - Physician C Q1 = 15 minutes
  - Physician C Q1 patient volume = 50
  - Q1 operating room direct variable cost / minute = $40
  - Physician C A1 savings = (45 – 15 minutes) x 50 patients x $40 / minute = $60,000

- **EKGs – calculate costs per patient and utilization**

- **Stents**
  - Average costs per stent and average utilization stent/patient
  - Calculate actual per-physician costs
  - Determine savings
Gainsharing

Example

DRG 231 – Coronary Bypass with PTCA w/o MCC

900 Medicare Admissions

Medicare Part B Physician Payment = $1,065,000

$ 300,500 Gainshare Opportunity (25%) ÷ 700 Cases = $ 429 Per Case Gainshare Opportunity
Next Steps

- Applied for Model 4
- Scalable system attributes from ACE
- Goals – Triple Aim
  - Physician alignment
  - Reduce costs – increase efficiency
  - Improve quality performance
  - Get really good at managing Medicare patients – it’s 50% of our business
- *Become accountable with delivering care*
High-Level Overview for AHT Project

• We anticipate a 3-year timeline:

  - Develop Plan
  - Implement Plan
  - Communicate & Engage

**Operational Levers**
- Labor Productivity, Revenue Cycle, Supply Chain, Administrative (System Services)

**Utilization Levers**
- Utilization Management and Reduction in Unnecessary Variation in Care

**Portfolio Levers**
- Outpatient Growth, Surgical Services Growth, Program and Service Line Contribution Margin Analysis

**Clinical / Quality Levers**
- Readmission Rates, Core Measures, and Care Experience Performance
## Cost Sharing in the Exchange

### Sample

<table>
<thead>
<tr>
<th>Cost Sharing Amounts Consistent with Actuarial Valuation</th>
<th>Without Cost Sharing</th>
<th>Bronze Small Employer</th>
<th>Silver Package</th>
<th>Gold Package</th>
<th>Platinum Package</th>
<th>Catastrophic</th>
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<td>Deductible – Single</td>
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<td>Deductible – Family</td>
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<td>Prescription Drugs Coinsurance</td>
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<td>Preventive Care Coinsurance</td>
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<td>Copayment limit – Single</td>
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<td><strong>PMPM in 2011</strong></td>
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<td><strong>$254</strong></td>
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The Act also reduces the maximum out-of-pocket spending limits by income level:

- Less than 150% FPL: .94 (coinsurance = 8%)
- 150% to 200% FPL: .87 (coinsurance = 10%)
- 200% to 250% FPL: .73 (coinsurance = 25%)
- 250% to 400% FPL: .70 (coinsurance = 25%)
Thank You

• Questions?

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and Exempla Healthcare

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