Triad HealthCare Network

Physicians Partnering with CONE HEALTH

Medicare / Accountable Care Organization

CHS Finance Division CPE Day

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Agenda

- THN - History and Structure
- Experiences and Learnings
- Next Generation ACO Decision Process
- Additional Strategies to Manage Risk
- Vision for the Future

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What is an Accountable Care Organization (ACO)?

- Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their patients.
- The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors.
- ACOs' success can be measured by reporting quality metrics for defined populations of patients and spending health care dollars more wisely leading to lower costs.

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History and Overview

- Began as a 20-member physician-led steering committee in fall 2010
- Developed over eight months as collaboration between independent and employed community physicians and Cone Health
- Formed officially in 2011 as a Clinically Integrated Network serving the Piedmont Triad area; Approved as a Medicare Shared Savings Program ACO in June 2012 (40,000+ beneficiaries)
- Is an affiliate of the Cone Health System, but governance and operations is led and driven by physicians

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Goals

- Allow physicians to lead and drive the necessary changes in healthcare
- Engage physicians to develop new models of care and true "transformation" of the local healthcare delivery system
- Provide resources to physicians to meet the growing demands of accountability and transparency
- Create greater collaboration and trust among physicians, hospitals, patients and payers
- **Be renowned as a clinically integrated system of care delivering superior value measured by high quality outcomes, affordability and exceptional customer experience**

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Structure and Membership (as of October 2015)

- 1,000+ Affiliated physicians representing 80+ entities across four counties
  - 360 employed by Cone/ARMC
  - 60% independent community physicians
  - 30+ EHR platforms
- 300+ Primary Care Physicians (Adult and Peds)
- Facilities
  - 6 Hospitals - 1,342 Acute Care Beds
  - 2 Ambulatory Surgery Centers
  - 1 Nursing Home – 92 Beds
  - 2 Freestanding Ambulatory Care Campuses, Inc a Freestanding ED

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Current Contracts

• Medicare Shared Savings Program*	35,000
• Cone Health employees/dependents*	16,000
• Humana Medicare Advantage**	14,000
• United Medicare Advantage*	10,000
	75,000 Patients

* Shared savings agreement

**Take full global capitated risk on 11,500 Humana HMO Gold members; Shared savings agreement on 2,500 Humana Medicare Advantage PPO

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Medicare Shared Savings Program

- THN began participation as an ACO in the Medicare Shared Savings Program (MSSP) in July 2012 with 40,000 Medicare Members
- Original program had two tracks:
  - Track 1: Up to 50% Savings and no downside risk (99%)
  - Track 2: Up to 60% Savings with downside risk
- Original agreement with CMS was for 3.5 years
  - Began July 2012 and expires in December 2015
  - Three performance periods: 1) July 12-Dec 13; 2) Calendar year 2014; and 3) Calendar year 2015

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Medicare Shared Savings Program

- At the end of original term, 3-year renewal period to required taking downside risk
- Performance: $25M to date
  - PY1: July 2012 - December 2013 (18 months)

Historical Benchmark	$463,194,583
Actual Performance	$441,688,961
Savings of 4.6%:	**$ 21,505,622**

Savings Distribution → **$10,537,755**

  - PY2: January 2014 – December 2014

Historical Benchmark	$307,105,802
Actual THN Performance	$303,532,135
Savings of 1.16%:	**$ 3,573,667**

Savings Distribution → **$0**

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Medicare Shared Savings Program: Challenges

- Beneficiary Alignment – Retrospective, Plurality of E&M Codes, includes Specialists, varies quarterly, final list unknown until last quarter
- Timeliness of Data – Receive quarterly reports and membership changes months after the fact, e.g., 2nd quarter received in Nov
- Short term "shelf life" – benchmark is historical which factors in savings generated; increases difficulty to earn savings
- Minimum Savings Rate - Can generate savings, but get no "share"
- Difficult to achieve savings in already efficient areas – historical benchmarks are lower ($8,600 THN versus $11,750 Houston)
- Savings amounts limited (50%-60%) and significantly impacted by quality scores

Patient Assignment to THN

Added to TN Panel	# of Members	List received from CMS	% of Total
2011 Original	18750		52.45%
2012 Q3	3475		9.72%
2012 Q4	1259		3.52%
2013 Q1	1040		2.91%
2013 Q2	1130		3.16%
2013 Q3	931	Nov-13	2.60%
2013 Q4	1159	Feb-14	3.24%
2014 Q1	1563	May-14	4.37%
2014 Q2	1344	Aug-14	3.76%
2014 Q3	1483	Nov-14	4.15%
2014 Q4	1734	Feb-15	4.85%
2015 Q1	280	May-15	0.78%
Final 2014	84	Aug-15	0.23%
Retro 1	9	Jan-14	0.03%
Retro 2	1510	Mar-14	4.22%
Grand Total	35751		100%

3,590

10%

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MSSP vs NextGen ACO

- **Benchmark:**
  - **Next Gen benchmark is based off experience for 2014**, which was a high expenditure year for THN.
  - **MSSP uses a weighted average of three years**, with shared savings added back in. Because 2013 was a pretty favorable year, even when adding in the earned shared savings the expenditures for that year are fairly low, which translates to a lower benchmark.
- **Risk Scores:** NextGen allows up to a 3% increase in benchmark due to risk scores; MSSP only adjusts downward.
- **Regional Trends:**
  - **Next Generation benchmark uses national trends, adjusted for regional AWI and GPCI.**
  - This results in a higher trend than the assumed ACO trend, and produces more favorable results compared to MSSP.

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NextGen ACO Benchmark Projections

		NGACO: 100% Risk		
Description	**CY 2014**	**CY 2016**	**CY 2017**	**CY 2018**
Baseline/Benchmark PMPM Medical Expense	$732	$741	$771	$816
Risk Ratio ***(Can increase up to 3% per year - held flat)***		1.000	1.000	1.000
Annual Regional Projected Trend	1.60%	0.7%	4.2%	5.8%
Average Number of Beneficiaries		36,000	36,000	36,000
Parameters				
Quality Performance Measures		100%	85%	85%
Regional Efficiency		0.990	0.990	0.990
National Efficiency		1.001	1.001	1.001
Maximum Savings Percentage		100%	100%	100%
Maximum Profit		15%	15%	15%
Maximum Loss		15%	15%	15%
Discount Factor		1.10%	1.25%	1.25%
PMPM				
Maximum Profit		$111	$116	$122
Maximum Loss		($111)	($116)	($122)
Annual (in 1,000's)				
Maximum Profit		$48,040	$49,990	$52,866
Maximum Loss		($48,040)	($49,990)	($52,866)

Benchmark impacted by:

- **Regional Trend**
- **Risk Ratio**
- **Discount Factor (includes quality score)**

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MSSP vs NextGen ACO Modeled Performance

Modeled Shared Saving Comparisons (Aggregate, 000's)

	MSSP AP2: Track 3			Next Gen: 100% Risk		
Annual Savings	**CY2016**	**CY2017**	**CY2018**	**CY2016**	**CY2017**	**CY2018**
-1.0%	$0	$0	$0	$5,725	$7,466	$10,052
-0.5%	$0	$0	$6,001	$7,282	$10,644	$15,005
0.0%	$0	$6,022	$9,239	$8,839	$13,806	$19,909
0.5%	$5,066	$8,080	$12,444	$10,396	$16,953	$24,766
1.0%	$6,249	$10,127	$15,616	$11,953	$20,084	$29,576
2.0%	$8,615	$14,191	$21,867	$15,068	$26,299	$39,053

* A negative savings illustrated here indicates costs above the baseline

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Strategies to Impact 2015 MSSP – Last quarter

- Priority Practice Efforts
- Every Practice Priority Patient Initiative
- Supporting High Risk Initiative

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Strategies to Impact 2015 MSSP – Last quarter

- Priority Practice Efforts
  - Bring additional project management and care management to practices with high numbers of high risk patients
  - Process
    - Identify practices (7 main ones; 5 minor ones)
    - Written letter with background info and specific patient list – sent

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Strategies to Impact 2015 MSSP – Last quarter

- Every Practice Priority Patient Initiative
  - Identify 5-10 high risk/freq adm/hotspotters per provider
  - Ask practices to contact patients
    - If seen recently, telephone contact to assure they are doing okay, review meds, be sure they get flu shot, assess barriers
    - If not seen recently, ask patient to come in for visit to assess stability, review meds, be sure they get flu shot, assess barriers
  - Will go out over next two weeks
    - Email from PCP Medical Dir. to all PCPs sent out 10/27
    - Letter with list is being hand-delivered to PCP sites

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Strategies to Impact 2015 MSSP – Last quarter

- High Risk Initiative
  - Moses Cone, Wesley Long, and Annie Penn hospitals
  - Patients in the following categories fall into the HRI
    - Readmissions
    - Complicated ICU stay
    - ICU stay with sepsis
    - Complicated CHF
    - Complicated COPD
    - Other diseases for which they are frequently admitted
    - LOS > 11 days

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Strategies to Impact 2015 MSSP – Last quarter

- High Risk Initiative
  - Bi-weekly LOS Team Meetings
    - Attended by Dr. Aronson, CM team, SW team, four HH agencies, THN Hospital Liaisons
    - Desire to refer to HRI 48-72 hours before d/c
  - HH agency sees patient on day of or day after d/c (incl weekends)
    - HH follows patient for at least 30 days if possible
    - HH interacts with PCP for further orders
  - Dr. Aronson is potential backup if PCP will not respond
  - HH agency or PCP can initiate direct admission to SNF by contacting CM team (± assistance of Dr. Aronson)

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Strategies to Impact 2015 MSSP – Last quarter

- High Risk Initiative
  - THN role
    - Help identity additional subsets of patients who are at high risk for readmission
      - MSSP patients who refuse SNF services although recommended by therapies and attending physician
      - Possibly patients who are borderline for SNF need in the first place
    - Help with needs of certain MSSP patients
      - Mobile Meals
      - Personal Care Assistance
    - Help with direct admission to SNF of MSSP patients to avoid readmission
    - Help in publicizing HRI program to PCPs

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Strategies to Prepare for Risk Under NextGen ACO

- Transition of care project
  - Treating discharges as ‘admissions to home’
- Specialist data project
- Skilled Nursing Facility LOS project
- Mobility project
- Project “Quantify”
- Expand Care Management to Rising Risk
- Care Variation Analytics Project

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Vision for the Future

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Vision for the Future

The best way to predict the future is to create it

-Abraham Lincoln

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Vision for the Future

- Shift to capitated risk and develop a single community care model
- Create payment system to align behavior around improvement of quality, cost and access.
- Develop high performance network of preferred providers and community partners
- Collaborate with physicians to improve hospital efficiency
- Develop and monitor outcomes that are important to individuals
- Be renowned for highest quality and most integrated care