Healthcare Leadership Council

Best Practices for Assessing and Driving Value in Healthcare

7/14/2017

Andrew Baskin, MD
National Medical Director, Quality and Clinical Policy
The value of payer-provider collaboration

Building on the strengths of providers and payers creates a stronger future for accountable care based on shared goals.

 PROVIDERS

- Community presence
- Patient relationships
- Point-of-care data
- Clinical delivery

Collaboration and transparency

Quality and efficiency

Aligned Incentive

Enhanced Member Engagement

 Payers

- Population health expertise
- Insurance operations
- Financial risk management
We align the reimbursement package to drive improvement where it is most impactful

- For practices with large primary care volumes, we focus on Population Models like PCMH and ACOs
- For specialists and hospitals that are not integrated with primary care, P4P and Bundled Payments work well
- Large integrated systems may require a mixture

<table>
<thead>
<tr>
<th>Performance</th>
<th>Practice Demographics</th>
<th>Practice Capabilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Quality of Care</td>
<td>• Primary Care</td>
<td>• Population Health</td>
</tr>
<tr>
<td>• Patient Experience</td>
<td>• Specialty Mix</td>
<td>• Team-Based Care</td>
</tr>
<tr>
<td>• Utilization Efficiency</td>
<td>• Facilities Owned</td>
<td>• EMR</td>
</tr>
<tr>
<td>• Episodic Cost of Care</td>
<td>• Footprint</td>
<td>• Performance Improvement</td>
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<td>• Total Cost of Care</td>
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<td>• Manage Risk</td>
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<tr>
<td>• Access</td>
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<td>• Innovation</td>
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</tbody>
</table>

Ideal partners for ACO Product models have strengths in all of the boxes
Value-based contracting program portfolio

VBC reimbursement programs

Pay for performance (P4P)
- Physician & hospital; Quality & efficiency

Patient Centered Medical Home (PCMH)
- Primary care and oncology; Team-based care; Quality & efficiency

Bundled payments
- Specialty care; provider assumes risk for episodic costs & quality

ACO attribution
- Total cost of care & quality for population of members attributed

ACO product
- Total cost of care & quality for population of members who enroll in a product; benefit design and new patient growth

VBC reimbursement with health plan products

Joint ventures
- Payer & provider launch a new company
- Share overall business results; Total cost of care and quality
Attribution & Product ACOs

What is similar?

Provider financial opportunity is tied to performance on quality, cost, and efficiency.

Aetna shares information:
- Efficiency metrics: performance against targets, tracking of each metric by month, detailed views on all metrics
- Financial tracking: pmpm’s by type of service (medical cost category), by month and by system (spend within and outside of ACO)
- Member details: ER frequent fliers; Inpatient outlier cases; high cost members; high risk members; gaps in care; daily census for IP, ER, CM/DM
- Raw data files

Provider is accountable and has capabilities to:
- Close gaps in care, use registries
- Use EMR, registries
- Implement multidisciplinary team care
- Collaborate with Aetna to strengthen case management
- Extend access

Many sources of savings are similar:
- Earlier identification and better involvement of provider teams to manage high-risk patients
- Evidence-based, efficient treatment pathways
- Data-driven referrals and site-of-service
- Manage quality to prevent co-morbidities and complications that lead to hospitalization
- Efficient prescribing – therapeutic equivalents, generic, etc.
Our Product ACOs are unique

What is different?

**ATTRIBUTION ACOs**

All Members are included in the ACO by their use patterns, may not know anything unique about the program

1-2% reduction in trend *

Provider rewarded if trend for attributed patients beats comparative market trend

Slightly longer turn around on reporting to help providers identify patients in need of proactive care

At risk members can be identified, just not as soon due to the attribution process

Compliment a Product model by rewarding quality & efficiency patterns that accrue benefits outside of the Product model membership

**PRODUCT ACOs**

Members actively select a benefit plan, and are educated about how it works

8-15% savings targeted compared to Aetna broad network plans from fees and well-focused and aligned improvement tactics*

Provider shares in product profitability

ACO has stronger interest and participation in product growth, network and benefit design and cost competitiveness

Faster turn around on reporting to find at-risk members quickly – gold card identifies member at point of care

Providers can hone in on members sooner to deliver heightened level of care

*Actual results may vary, savings may be less when compared to other value-based network plans.
# Comparison of value based care models

<table>
<thead>
<tr>
<th>Reimbursement Models</th>
<th>Accountable Care Organization (ACO) Attribution</th>
<th>ACO Product</th>
<th>Joint Venture</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pay-for-Performance (P4P)</td>
<td>Specialty care model:</td>
<td>Population health model manages all care for attributed members:</td>
<td>Population health model with participation in a health plan:</td>
</tr>
<tr>
<td></td>
<td>2. Eliminate waste</td>
<td>2. EHR</td>
<td>2. Opportunity to attract new patients</td>
</tr>
<tr>
<td></td>
<td>3. Align to evidence-based best practices across practitioners and sites, and over a period of time</td>
<td>3. Enhanced collaboration and integration with Aetna care management programs</td>
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<tr>
<td>Patient Centered Medical Home (PCMH)</td>
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<tr>
<td></td>
<td>Primary care model:</td>
<td></td>
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<tr>
<td></td>
<td>1. Team-based care</td>
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<tr>
<td></td>
<td>2. Electronic Health Record adoption</td>
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<tr>
<td></td>
<td>3. Enhanced collaboration with Aetna care management programs</td>
<td></td>
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<tr>
<td>Bundled Payment</td>
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<tr>
<td>Accountable Care Organization (ACO) Attribution</td>
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<td></td>
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<tr>
<td>Provider Fit</td>
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<tr>
<td>Primary Care, Cardiology, Orthopedics, OB-Gyn, multispecialty practices and hospitals</td>
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<tr>
<td>Primary care medical home practices</td>
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<tr>
<td>Orthopedics, Cardiology, Maternity, Multispecialty practices, Post-Acute providers, and Hospital systems</td>
<td></td>
<td></td>
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<tr>
<td>Health systems, clinically integrated networks (CINs) and large primary care systems</td>
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<tr>
<td>Health systems and/or clinically integrated networks (CINs)</td>
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<tr>
<td>Health systems and/or clinically integrated networks (CINs)</td>
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<tr>
<td>Financial Goal</td>
<td></td>
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<tr>
<td>To shift portion of traditional FFS payments to compensation based on quality and/or financial performance</td>
<td>To reduce the total episode costs for targeted procedures through reducing complications, waste, and maintaining and/or improving quality performance.</td>
<td>To create financial accountability for the total cost of care by transitioning FFS payments to ACPs and compensation based on quality and total cost of care management.</td>
<td>Implement best in market product pricing to engage members. Providers share in health plan savings and risk, based on clinical and financial performance</td>
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<tr>
<td>To align incentives around quality and/or efficiency metrics.</td>
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</tbody>
</table>
Two simple approaches for capitalizing on ACOs in your benefit strategy

MARKET APPROACH

Aetna Whole Health ACO product

NATIONAL APPROACH

Aetna Premier Care Network

The best combination of network access and savings in a single solution

ACO, PCMH, IOQ and Radiology Labs, APN/Savings Plus, Aexcel, Broad network
Public Policy Challenges
Facing Value Based Frameworks

- **Inflexible Pricing Regulation**
  Medicaid best price, 340B drug discount program, and Part B rules create disincentives for health plans to undertake value-based frameworks. Plans need greater flexibility.

- **Federal Anti-Kickback Statute**
  Some discounts negotiated in VBC contracts to pay for results can technically be construed as illegal under longstanding anti-kickback rules. Language in this statute needs to be clarified to better accommodate VBC models – ideally via creation of safe harbors allowing manufacturers and plans to engage in VBCs.

- **Information Sharing**
  VBC contracts often require exchange of health economics and outcomes research (HEOR) data between manufacturers and plans. FDA should clarify guidance to facilitate HEOR information in VBC arrangements.

**MACRA – New Kid on the Block**
Congress’ 2015 physician payment overhaul will begin driving greater value-based payment in Medicare as soon as 2018 – and ripple effects in commercial markets are expected to follow.

- Providers may demand greater risk bearing as they strive to qualify for new bonus payments.
- Payers may need to modify current payment models if they want participating providers to be able to qualify for these bonuses, even if the models are proven to be successful.
Appendix
## Pay-for-Performance (P4P)

### Provider Match
- Primary Care
- Cardiology
- Orthopedics
- OB-Gyn
- Multispecialty Practices
- Hospitals

### Collaboration Features
- **Portion of fee-for-service shifted to incentives** for improvement quality measures as a first step into VBC
- **Data sharing, scorecard, and quarterly meetings**
- Payment dependent on improving performance or maintaining already high performance

### Measure Examples
Readmissions, Adverse Event Rates, Risk-Adjusted C-Sections, Patient Experience, Preventive Care and Screening, Chronic Disease Management, Generic Rx, Participating Provider Status
### Patient-Centered Medical Home (PCMH)

#### Provider Match
- Primary Care
- >1500 but <5000 attributed members

#### Collaboration Features
- **Primary care model** with attribution-based ACP payments and incentives for quality and efficiency improvements
- Data and performance reports (quarterly, monthly, daily) and quarterly meetings
- Providers coordinate care with Aetna care management programs

#### Quality Measure Examples
- Preventive Care and Screening, Chronic Disease Management

#### Efficiency Measure Examples
- Readmissions, Potentially Avoidable ED Visits, Bed Days, Participating Provider Status, Generic Rx
# Bundled Payment

## Provider Match
- Orthopedics
- Cardiology
- Ob-Gyn
- Multispecialty Practices
- Post-acute providers
- Hospitals

## Collaboration Features
- **Episode-based care model** with opportunity for provider to retain savings generated through coordination of care, reducing waste, avoiding complications, and deploying evidence-based practices across practitioners and sites.
- **Data reports and quarterly meetings**
- **Episode payment** covers defined period of time, complications and adverse events, providers across the continuum including facilities.
- **Opportunity for additional incentive** for measured quality improvements

## Bundle Examples
- Hip Replacement, Knee Replacement, Shoulders, Spine Surgery, Maternity Care, PCI, CABG
## Accountable Care Organization Attribution (ACOA)

### Provider Match

- Integrated delivery systems (IDS)
- Clinically integrated networks (CINs)
- Large primary care systems
- >5000 attributed members

### Collaboration Features

- **Population health model** where portion of reimbursement is shifted from fee-for-service to ACP payments and incentives tied to quality and cost of care improvements, with risk for poor performance
- **Data, reports (quarterly, monthly, daily)** and quarterly meetings
- **Providers use team-based care, EHR, and enhanced collaboration** with Aetna care management programs

### Quality Measure Examples

Preventive Care and Screening, Chronic Disease Management
**Accountable Care Organization (ACO) product – a health plan product**

### Provider Match

- Health systems, integrated delivery systems (IDS), hospitals and large physician practices
- Willingness to provide best-in-class premium pricing

### Collaboration Features

- **Grow membership** with best-in-market PMPM medical costs and quality measure improvements
- **Population health model** where provider shares in product savings and risk. Payment levels are adjusted for quality performance.
- **Data, reports (quarterly, monthly, daily) and quarterly meetings.** Clinical transformation and coaching.
- **Providers use team-based care, EHR, and enhanced collaboration** with Aetna care management programs

### Quality Measure Examples

Preventive Care and Screening, Chronic Disease Management
Joint Venture (JV) Health Insurance Company – a payer-provider partnership

<table>
<thead>
<tr>
<th>Provider Match</th>
<th>Collaboration Features</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Health systems, integrated delivery systems (IDS) and hospitals</td>
<td>Jointly owned health insurance company with economics and governance aligned by a payer-provider partnership</td>
</tr>
<tr>
<td>• Clinically integrated networks (CINs)</td>
<td><strong>Share capabilities, membership growth, and earnings and risk</strong> in a model that uses the core competencies of each party to create financial opportunity</td>
</tr>
<tr>
<td>• Willingness to form a new company</td>
<td><strong>Breakthrough consumer experience</strong> by creating one health care point-of-contact, dedicated to integrated, efficient processes</td>
</tr>
</tbody>
</table>

**Incentive**

• Rewards providers by putting them in the business of health insurance
VBC Reporting Package Tailored to Plan Sponsors

The plan sponsor VBC reporting package offers a financial summary view, while also providing clinical and trend performance results.

<table>
<thead>
<tr>
<th>Member Profile - Current</th>
<th>Product VBC</th>
<th>Attributed VBC</th>
<th>Non-VBC</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Aetna Whole Health</td>
<td>Attributed ACO</td>
<td>Attributed PCMH</td>
<td>Non-VBC</td>
</tr>
<tr>
<td>Average Medical Members</td>
<td>5,341</td>
<td>6,514</td>
<td>2,273</td>
<td>59,808</td>
</tr>
<tr>
<td>Percent of Total Medical Members</td>
<td>5.7%</td>
<td>7.0%</td>
<td>2.4%</td>
<td>64.4%</td>
</tr>
<tr>
<td>Percent of Total Allowed</td>
<td>7.0%</td>
<td>7.1%</td>
<td>2.8%</td>
<td>83.1%</td>
</tr>
<tr>
<td>Average Retrospective Risk Score</td>
<td>1.27</td>
<td>1.31</td>
<td>1.31</td>
<td>1.08</td>
</tr>
<tr>
<td>Allowed PMPM excluding High Cost Claimants(^1) (\text{risk adjusted})</td>
<td>$252.15</td>
<td>$215.61</td>
<td>$234.69</td>
<td>$341.94</td>
</tr>
<tr>
<td>Geographic Factors</td>
<td>0.988</td>
<td>0.939</td>
<td>0.983</td>
<td>0.960</td>
</tr>
<tr>
<td>Number of Organizations Represented</td>
<td>2</td>
<td>61</td>
<td>40</td>
<td>N/A</td>
</tr>
</tbody>
</table>

\(^1\) High Cost Claimant threshold is $100,000

The data on this table include all members, not just those who have gone through reconciliation.

<table>
<thead>
<tr>
<th>Accountable Care Organizations (ACO) Reconciled Population – Plan Sponsor</th>
</tr>
</thead>
</table>
| ACOs have different goals than PCMHs and include financial, clinical, and efficiency measures. The results for the Attributed ACOs aggregate the experience of each organization compared to the market.
| • Historical context: Large, integrated health systems typically have had trend higher than the market. Holding these systems to market trend and aligning incentives for beating market trend can be a significant challenge for them, but it is a challenge that we jointly agree is possible through clinical transformation. That goal can take some time to achieve, but members and customers are better off with trend improvement, even if that trend performance doesn’t yet beat the market.
| • Small numbers impact the results seen for this subpopulation.
| • 70% of members attributed to an ACO are utilizing a reconciled arrangement.

<table>
<thead>
<tr>
<th>Attributed ACO Member Profile</th>
<th>Current Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Medical Members</td>
<td>4,557</td>
</tr>
<tr>
<td>Percent of Total Medical Members</td>
<td>5%</td>
</tr>
<tr>
<td>Average Pharmacy Members</td>
<td>0</td>
</tr>
<tr>
<td>Percent of Total Pharmacy Members</td>
<td>0%</td>
</tr>
<tr>
<td>Average Age</td>
<td>34</td>
</tr>
<tr>
<td>Average Retrospective Risk Score</td>
<td>1.32</td>
</tr>
</tbody>
</table>

*Reconciled Population: Members that are attributed to a VBC arrangement that has been in place at least 12 months. Reconciliations are completed on a quarterly basis and allow for constant comparison to the market.
*Weighted Efficiency Index: This is an index created by comparing ACO reconciled deals to the market. An index above 1.0 means the ACO is not performing as well as the market and an index below 1.0 means the ACO is performing better than the market.

But the report also provides a view of reconciliation and trend performance...

- Reports are available semi-annually.
- The report continues to evolve (version 2.0) and additional enhancements are scheduled.
In addition to financial performance, the report shows clinical performance.

The report shows quality and efficiency performance for members who in ACO and PCMH models.

The report compares the performance of plan sponsor members in VBC compared to the plan sponsors’ total population.

Where available, Aetna BOB performance is used as a comparison.

Clinical performance continues to improve over time as providers transform clinically and actively engage with Aetna in population health management.
Best Practices for Assessing and Driving Value in Healthcare

MemorialCare’s Focus on Revolutionizing Value

June 2017, Healthcare Leadership Council
Helen Macfie, Pharm.D., FABC
Chief Transformation Officer
## About MemorialCare

### Total Assets
- Annual Revenues: $2.2 billion
- Bond Rating: AA-stable

### Hospitals
- Patient Discharges: 67,000
- Patient Days: 317,000
- ER Visits: 214,000
- Babies delivered: 10,500
- Surgeries - IP/OP: 34,000

### Ambulatory Access
- “At Risk” Lives/ACOs: 259,000
- Seaside Health Plan: 39,200
- Medical Group Visits: 600,000
- Ambulatory Surgeries: 44,000

### Workforce
- Employees: 11,000
- Affiliated Physicians: 2,600
- Employed Physicians: 230
What made us go down this path?

**Strategic Aim**
- **Right thing to do**
- Shifting from Hospital-Based to **Integrated System of Care**
- **Differentiator**
- Learning, **paradigm shift**

**FROM**
- Pay for procedures
- Fee-for-service
- More facilities/capacity
- Physicians/hospitals acting independently
- Physicians and Hospitals working in parallel
- Hospital centric
- Treat disease/episode of care

**TO**
- Pay for value
- Case rates/budgets/capitation
- Better access, appropriate settings
- Physician/hospital collaboration: global risk
- Physicians and hospitals working in a highly integrated manner
- Continuum of care (population centric)
- Maintain health

- **Same Store**
- **Regional Partnerships**
  - Employers
  - Health plans
  - Hospitals

- **Ancillary**
- **Clinical**

**STRATEGIC PARTNERSHIPS**

- **INTEGRATION**

- **REVOLUTIONIZING VALUE**
  - Patient Centricity
  - Ease & Access
  - Systemness

- **POPULATION HEALTH**
  - ACOs
  - DTE
  - Bundled Payments
<table>
<thead>
<tr>
<th>ACO or At Risk</th>
<th>Attribution and Key Descriptors</th>
</tr>
</thead>
</table>
| **Anthem**                     | • PPO, shared savings, no downside risk  
|                                | • # Lives: 33,759  
|                                | • Reduced cost by 11% on pmpm                                                               |
| **aetna** | HMO, downside risk on professional claims  
| **MemorialCare Health System** | • # Lives: 25,000+ across 7 Health Systems  
| **Vivity** offered by Anthem | • 7 Founders, shared savings  
| | **Blue Cross** | • # Lives: 25,000+ across 7 Health Systems  
| **CMMI Next Gen**             | • Medicare FFS, downside risk 5% year 1  
| **MemorialCare Regional ACO** | • # Lives: 17,177  
|                                | • One of 18 in 2016, one of 45 in 2017                                                        |
| **MemorialCare Health Alliance** | Direct to Employer with Boeing, PPO  
| **Phil-Health** | Convener, downside risk shared  
| | **UC Irvine Health** | • # Lives: 8,985  
| **SEASIDE Health Plan**       | • Medi-Cal (Medicaid), Medicare, limited Commercial  
| **MemorialCare Health System** | • # Lives: 39,900 total  
| | **Excellence in Health Care** | **BPCI Model 2: Retrospective Acute & Post Acute Care Episode**  
|                                | • Medicare FFS  
|                                | • Cases: 700 annually – CABG, PCI, Hip/Knee  
|                                | • One of 539 in Model 2  
|
Evolving our 3D care model

PATIENT RISK

High Risk

Low Risk

CONTINUUM OF CARE

Least Intensive

Most Intensive

Wellness & Prevention
- Health Coaching
- Preventive Screenings
- Vaccination Outreach

Disease Management
- Risk Stratification
- COPD – CHF – Diabetes

Hospital Care
- 24/7 Hospitalists
- Discharge Clinic

High Risk
- Virtual Case Conference
- Complex Case Management

Late Stage
- Palliative Care
- Hospice

Specific High Risk Conditions
5%

Chronic Illness ED and Hospital Usage
20%

Early Disease Symptoms (increased BP, pre diabetes)
40%

Wellness and Preventive Care
35%

Late Stage Illness
Results - mostly positive...

**ACO Shared Savings / Care Coordination Earnings**

<table>
<thead>
<tr>
<th>A</th>
<th>Quality Scorecard - 100%</th>
<th>Yr 1 - $1.5M</th>
<th>Yr 2 - $917K</th>
</tr>
</thead>
<tbody>
<tr>
<td>B</td>
<td>Yr 1 - $1.2M</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>Quality Scorecard - 100%</td>
<td>Yr 1 - $1.8M on risk pool savings</td>
<td></td>
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<tr>
<td>D</td>
<td>Reduced PMPM</td>
<td>Pending for Yr 1 (expect $ loss)</td>
<td></td>
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<tr>
<td>E</td>
<td>On target, meeting all deadlines</td>
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**30 day Readmissions, All Cause, All Payer**

[Graph showing 30 day readmissions data]
KEY LESSONS LEARNED
1. It is a strategic investment
2. Engage actuarial assistance
3. Partnering with others
4. Outreach, explain, make it easy
5. Patient centric support, involve
6. Don’t budget return in year 1!
7. Narrow networks \(\Rightarrow\) Designated.
8. Engage expert resources, early
9. Building & improving new tools
10. It takes a village, HR focus
11. Advocate for harmonization
12. Focus on social determinants
13. Leverage interest, collaboratives
14. Education on # needed to treat
15. Visibility, streamline, celebrate

Focusing only on ROI

Find the halo
Recommendations

WHAT WE’D LIKE TO SEE - Top 5

1. Continued support for innovation and sharing
2. Quality metric harmonization across ACO models
3. Address regulatory barriers – e.g. 3-Day SNF Rule
4. Bullish on Bundles (voluntary experience)
5. Evolve MACRA
   - MIPS alignment – consider 2018 changes going retro
   - More Advanced APM models

"The significant problems we face cannot be solved at the same level of thinking we were at when we created them."

- Albert Einstein (1879-1955)