America’s Physician Groups (APG)
Direct Contracting
Educational Series 2019

Risk-Based Contracts:
How to Make the Valuable Transition

July 17, 2019

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Today’s Presenters

Michael J. Lipp, MD, MBA, Chief Medical Officer, Center for Medicare and Medicaid Innovation (CMMI), Centers for Medicare and Medicaid (CMS)

Narayana S. Murali, MD, Executive Director of Marshfield Clinic; EVP & Chief Strategy Officer, Marshfield Clinic Health System, Inc.

Kelly A. Robison, Chief Executive Officer, Brown & Toland Physicians

What Will You Learn Today?

• CMMI will review the regulation content of the direct contracting models and provide additional relevant resources

• APG members will share competencies needed to be successful in the new direct contracting models. These subject matter experts will share the know-how necessary to operate risk-based contracts successfully, sharing strategy and implications for their organizations.

• Shared strategies, best practices, and lessons learned
Michael J. Lipp, MD, MBA
Chief Medical Officer, Center for Medicare and Medicaid Innovation (CMMI), Centers for Medicare and Medicaid (CMS)

Innovation Center Primary Care Models

- Primary Care First
- Direct Contracting-Professional
- Direct Contracting-Global
- Next Generation ACO
- Vermont All Payer
- Comprehensive Primary Care Plus
- Maryland Primary Care Program
- Direct Contracting-Geographic
- Maryland Total Cost of Care Model
Narayana S. Murali MD FACP
Executive Director, Marshfield Clinic
EVP Care Delivery and Chief Strategy Officer, Marshfield Clinic Health System

Success in Risk-Based Contracts
Learning Objectives

• Who Are We, Our Journey
• Infrastructure Needed
• Why the Value Based Model is Better for Patients
• Lessons Learned
OUR JOURNEY
of participating in Upside Only value contracts

- CMS PGP version 1 ~ $56M over five years
- Exceeded 130 of 133 quality metrics over 5 years

Shared Savings Earned in the PGP Demo (an ACO Precursor)
(in millions of dollars)

Over 30,000 Medicare members in MSSP ACO

- 15% less costly than the average of ACOs participating in MSSP
- Gap maintained during PGP, Transition Demo and ACO participation

ENSURING ALIGNMENT CREATES VALUE

**Informatics is Strong and Analytics Weak**

"We have >90% CPOE rates, but our use of expensive resources has increased greatly since go-live."
"I know our informaticists do a great job with workflow, but they don't help us with our quality reporting."

**Informatics is Weak and Analytics Strong**

"No one looks at the great reports my team generates."
"Our analytics team has identified dozens of opportunities for clinical efficiency, but there's no one to hand the ball off to."

**Each is Strong; they Work Well Together**

"By partnering together, the Analytics- Informatics team solves problems better and faster."
"This is EXACTLY what I've been asking for!"
Departments work with ACE to provide subject expertise and set priorities

ACE works with Departments to deliver tools to build data competency and self-sufficiency

Departments and MCHS IS collaborate to expand application data and workflow, engaging Informatics, to resolve data source quality issues to support Analytics

MCHS IS (Application builders, advisory, tech support) MCHS IS provides technical, applications and informatics support to the enterprise

MCHS IS works with ACE to provide technical platforms and support for analytics

ACE works with MCHS IS to build analytics to support the MCHS application portfolio

Analytics Center of Excellence Elements of Collaboration View

Departments
(Leaders, data owners, stewards, resident analysts)

Departments and MCHS IS collaborate to expand application data, workflow and informatics, to resolve data source quality issues to support Analytics

MCHS IS (Application builders, advisory, tech support) MCHS IS provides technical, applications and informatics support to the enterprise

Analystics Center of Excellence
ACE leverages Data and Analytics Governance and provides analytics acumen and resources to support the enterprise

Analytics Portal

Reports

My Web Reports

Parameterized Reports

- Appointment Type Volumes
- Appointment Type Volumes by Department
- AVS Monthly Department Report
- Billed Amount
- Departmental FTE Summary
- Departmental FTE Summary w\Transfer Detail
- Diabetic Eye Exam Not At Goal Patient List
- Diabetic Eye Exam Patient List
- Encounter Reporting -Appointment Types Excluded\Included
- Generating FTE Reports
- HCC Gap Report with Patient Detail
- HTN Specialty Provider Report
- Individual FTE Summary w\Transfer Detail
- Internal Failure Detail
Strong Informatics & Analytics

- WHIO (The Wisconsin Health Information Organization)
- Med Markers (Cave Consulting)
- Med Insight - Health Waste Calculator
- Med Insight - Moderately Managed Benchmarks
- Feedback mechanism (Population Health Dashboards)
  - Quality of care
    - Outcome metrics
    - Process metrics
  - Patient experience
  - Utilization

Having the Right Pieces to Move to Full Risk

- Need to have congruent access to
  - Data – Claims, EMR
  - Analytics – baseline cost trends, risk corridors, attribution
- Control of ambulatory- acute care facilities in key markets
- Contracts – Business rules that work for all payers
- Development of care management programs that help to lower TCOC
  - Medicare – risk stratification, socio-economic factors, post-acute spend
  - Commercial - pharma, procedures,
- Innovation or programs - reduce the reliance on acute care beds
Exceptional Quality Scores

2016 Focus:
CMS MSSP Quality Payment Program

Ranked in Top 5% of all participants
(#18 out of 432 participants)

<table>
<thead>
<tr>
<th>Entity</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marshfield Clinic</td>
<td>98.5%</td>
</tr>
<tr>
<td>Baylor Scott &amp; White</td>
<td>98.4%</td>
</tr>
<tr>
<td>Cleveland Clinic</td>
<td>96.3%</td>
</tr>
<tr>
<td>Johns Hopkins</td>
<td>92.4%</td>
</tr>
<tr>
<td>UCLA</td>
<td>89.9%</td>
</tr>
</tbody>
</table>

Source: https://data.cms.gov

2017 Focus:
MACRA Quality Payment Program

Tied for First Place in Country

<table>
<thead>
<tr>
<th>Metric</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>&gt; 100%</td>
</tr>
<tr>
<td>Clinical Practice Improvement</td>
<td>100%</td>
</tr>
<tr>
<td>Advancing Care information (f/k/a Meaningful use)</td>
<td>100%</td>
</tr>
<tr>
<td>Overall MIPS Score</td>
<td>100%</td>
</tr>
</tbody>
</table>

Care Management : WMM?

Heart Failure Improvement Center

- Focus: Wellness & Chronic Disease Rx
- Strong PCP base/PCMH
- Care Management capabilities
  - Heart Failure
  - COPD & other chronic illness
  - Anticoagulation
  - Transitions of care
- Care Coordination - reduce redundant services
- Integrated EMR
- HIE capabilities are beneficial

Lower cost: right care, right time, right place
$2.7M
Net Financial Benefit

Population
• Security Health Plan
• 2016 Enrolled Cohort
• ~ 600 members

Over 1,150 Security Health Plan patients not enrolled – Potential additional benefit of $3.1 - $8.8 million

The Power of Integration
Financial Benefits shared by:

• Patient in the form of lower out-of-pocket costs for services and lower premium
• Security Health Plan supporting stable earnings
• Marshfield Clinic primary care providers and staff through value-based reimbursement programs designed to improve quality and resource efficiency plus address gaps in care

Medical Ethics of not doing it when you have significant positive outcomes

Hypertension Blood Pressure < 140/90
Percent of Patients at Goal

Marshfield Clinic Health System

• BP control rate has increased from 75% controlled to 87% of patients controlled
• Resulting in additional 5,250 patients now at goal that would not have been at goal in past
• NNT: 18 patients for 5 years to goal in order to prevent one heart attack or stroke
Outcomes

200
Heart attacks avoided

50
Strokes avoided

$13M
Saved over 5 years

*Estimated using the CDC Chronic Disease Cost Calculator for State of Wisconsin including only direct medical expenses, not indirect societal costs.


nAMD - Macular Degeneration

Retinal Medical Drug Treatments by Month for Wet Age Related Macular Degeneration

Current = 62%

MARINA, ANCHOR CATT

Lucentis 4 weeks
Eyelea 8 weeks
Avastin – off label

Avg. Spend $ 3.2B
Margin per Injection 106% ASP

$ 10 vs $ 111-117
Lessons Learned

• High Performing “Penalty”

• Long Term Investment Versus Short Term Measurement

• Benchmarking Cycle
Success in Risk-Based Contracts

Learning Objectives

• Understanding the Risk Model Continuum
• Identify Specific Infrastructure Requirements for Each Model
• Recognize the Importance of Patient-Centered Care
• Learn Strategies to Address the Total Cost of Care
• Define Key Success Factors for Risk-Based Contracts
Risk Model Continuum

Straight FFS
- Group level FFS contracts-paid based on codes billed
- MD bills and collects (direct to plan or through IPA)
- No claims or UM, (w/o mgmt. fee)
- Division of Financial Risk (DOFR) not necessary

Shared Savings Programs
- Group level agreement
- PPO patients attributed vs assigned
- FFS rates +incentives for quality/cost, only upside and benefit awarded for performance
- Can be multi-product
- Step towards greater risk for cost/quality

Shared Risk Model
- Group capitiated for professional services
- DOFR sets risk for group, hospital, and the health plan
- Group and capitated hospital partners or the plan share percentage of surplus/deficit
- Claims and UM usually delegated to group

Full Risk
- Group capitiated for professional services
- Hospital capitiated for all facility and hospital-based services
- Plan retains premium dollars and assumes risk for out of area emergencies or special carve outs

Global Risk
- Risk bearing entity capitiated globally (professional & hospital)
- Group is at 100% financial risk for all medical services with a few exceptions i.e. transplants, mental health
- Claims and UM delegated to IPA for all risk services

Brown & Toland Serves the Full Risk Continuum

<table>
<thead>
<tr>
<th>Payment Model</th>
<th>PPO</th>
<th>PPO ACO</th>
<th>Commercial HMO</th>
<th>Medicare Advantage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payment Model</td>
<td>FFS</td>
<td>Gainshare/ACO (FFS plus incentive)</td>
<td>Professional risk with additional incentives</td>
<td>Global risk</td>
</tr>
<tr>
<td>Administrative &amp; Clinical Support</td>
<td>Claims administration model</td>
<td>Claims administration model</td>
<td>Full delegation plus some advanced clinical services</td>
<td>Full delegation plus advanced MSO services</td>
</tr>
</tbody>
</table>
### Infrastructure Required for Each Model

<table>
<thead>
<tr>
<th>Operational Capability</th>
<th>ACO/Gainshare</th>
<th>Shared Risk</th>
<th>Global Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinical Services</strong></td>
<td>Some UM/Case/Disease Management</td>
<td>Delegated UM/Case/Disease Management</td>
<td>Delegated UM/Case/Disease Management</td>
</tr>
<tr>
<td><strong>Quality</strong></td>
<td>Risk/Quality Incentives</td>
<td>Risk/Quality Incentives</td>
<td>Risk/Quality Incentives</td>
</tr>
<tr>
<td><strong>Credentialing</strong></td>
<td>None</td>
<td>Professional/Some ancillary</td>
<td>All</td>
</tr>
<tr>
<td><strong>Claims Processing</strong></td>
<td>None</td>
<td>Professional/Some ancillary</td>
<td>All</td>
</tr>
<tr>
<td><strong>Member Eligibility Data</strong></td>
<td>Attribution reports</td>
<td>Eligibility file</td>
<td>Eligibility file</td>
</tr>
<tr>
<td><strong>Analytics</strong></td>
<td>Simple reports; provide cost population health, physician incentives</td>
<td>More complex capitation performance (claims paid, DOFR, Revenue)</td>
<td>Sophisticated population health modeling</td>
</tr>
<tr>
<td><strong>Provider Network Design</strong></td>
<td>Plan contracts and holds contracts</td>
<td>Group contracts and controls network, including redesign/narrow/tiering</td>
<td>Group contracts and controls network, including redesign, narrow and tiering</td>
</tr>
<tr>
<td><strong>Physician Compensation</strong></td>
<td>FFS with incentive</td>
<td>FFS and/or capitation plus incentive</td>
<td>FFS and/or capitation plus incentives</td>
</tr>
<tr>
<td><strong>Clinical Documentation</strong></td>
<td>Yes, limited</td>
<td>Yes, most programs</td>
<td>Yes, all programs</td>
</tr>
<tr>
<td><strong>Support services- legal, compliance, HR, IT, Portals, marketing</strong></td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

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**Physician & Patient at the Center of Care**

The physician with a focus on the patient drives all healthcare decisions.
Managing the Total Cost of Care

**Inpatient**
- Daily rounds
- Readmissions deep dives
- Transitions of Care Program
- Care Management: palliative/hospice

**Ambulatory CM**
- SNP
- Case identification
- CCM
- High need/high utilization

**Referral Services**
- Auto Authorization to 65%
- Embedded Contractual rules
- ASC, Home Health, DME
- UM metrics

**Pop Health**
- Cozeva - analytics
- CQDP: all seniors get AHA
- Clinical Quality Promotion across network
- Quality Programs (prevention/intervention)

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**Turnkey Physician Services Platform**

*Low cost clinical and practice management system for independent physicians across the Bay Area*

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**DATA WAREHOUSE**

<table>
<thead>
<tr>
<th>Finance</th>
<th>Claims System</th>
<th>Care Management</th>
<th>Reimbursement</th>
<th>STARS, P4P, HEDIS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infrastructure</td>
<td>Connectivity to Practices</td>
<td>Network</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Characteristics by Entity

<table>
<thead>
<tr>
<th></th>
<th>Physician Offices</th>
<th>BT Health</th>
<th>Brown &amp; Toland Physicians</th>
<th>BTHS</th>
<th>BTPSO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide patient care</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical staff employment (MDs, nurses, APPs)</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician office administrative support</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Direct Physician compensation</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Credentialing and Quality Assurance</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>HMO and PPO Contracting Entity</td>
<td></td>
<td></td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Physician Governance</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provider Contracts/Employment Agreements</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Knox-Keene License and Full Delegated Risk</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Claims adjudication and processing</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Negotiate HMO and PPO Contracts</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>EHR and physician productivity tools</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Billing and collections</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Strategic planning</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>

### Key Success Factors for Risk Business

- If you write the check, you should hold the contract
- The more risk you take, the more you need members assigned vs. attributed
- Delegation of key operations paramount to successful professional or global risk: claims, UM, credentialing
- Clinical documentation, population health modeling and complex care programs differentiate
- Robust compliance program
- Stop Loss/Reinsurance
APG Risk Readiness Tool

Hands-on tool to assess your readiness for APMs

Essential, specific checklists for:

- patient safety
- effective clinical care
- patient-centered care and provider communication
- care coordination
- population health

Available for download at www.apg.org/risktool
QUESTIONS

For more information:
APG's Educational Series 2019

Contact Dr. Amy Nguyen Howell
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