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# Trends in Care Delivery and Community Health

## State Public Health Leadership Webinar

Deloitte Consulting LLP

June 20, 2013

## Agenda

| | |
|---|---|
| Welcome | Paula Staley, MPA, RN<br>Senior Advisor, Office for State, Tribal, Local and Territorial Support, Centers for Disease Control and Prevention |
| Overview of Changes in Healthcare Delivery | Mike Van Den Eynde, MBA<br>Director, Deloitte Consulting LLP<br><br>Bob Williams, MD<br>Director, Deloitte Consulting LLP |
| Overview of Minnesota Experience | Ellen Benavides, MHA<br>Assistant Commissioner, Minnesota Department of Health |
| Overview of Massachusetts Experience | John Auerbach, MBA<br>Director, Institute on Urban Health Research and Practice |
| Question & Answer Session | All |

# Overview of Changes in Healthcare Delivery

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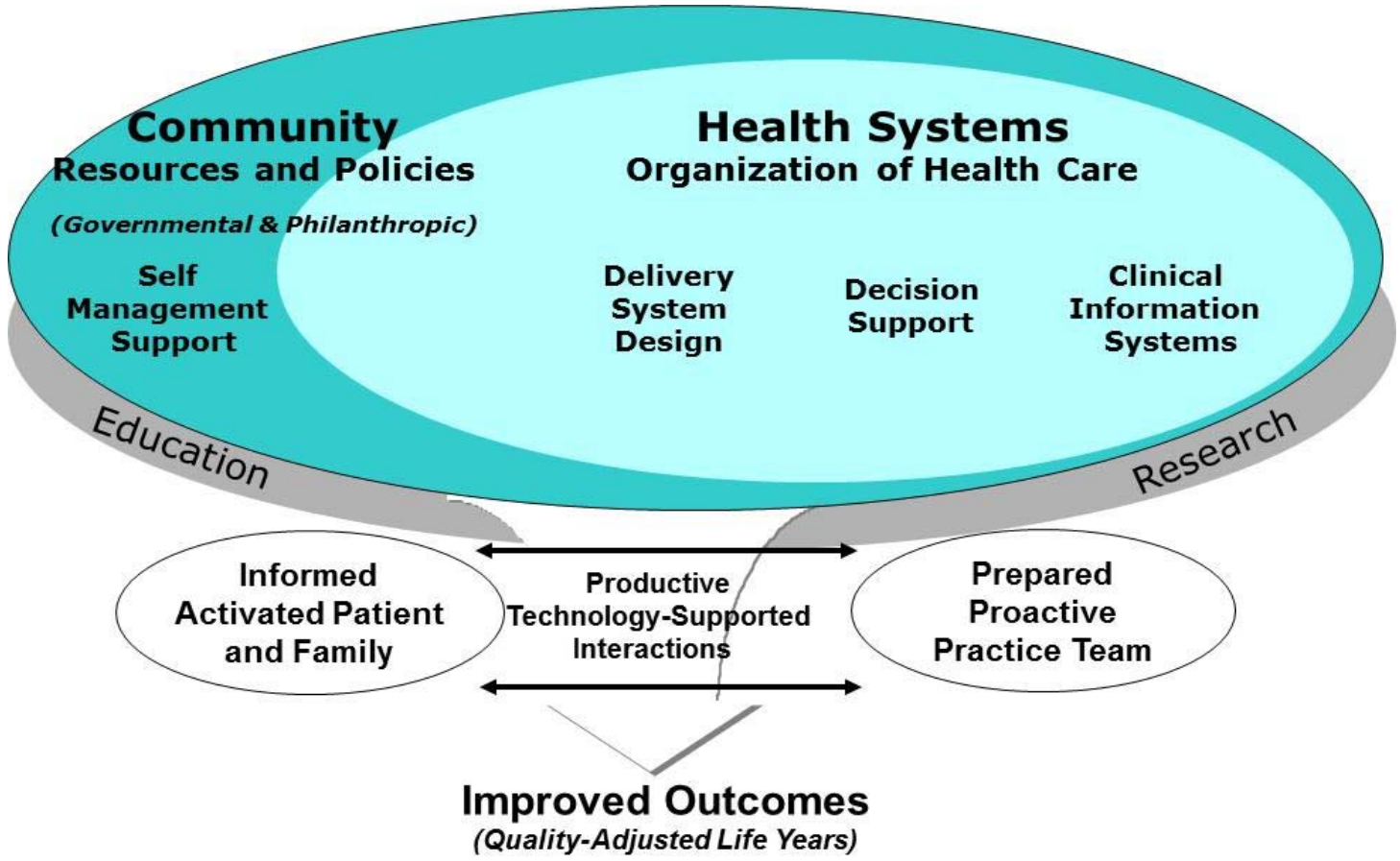
# Introduction

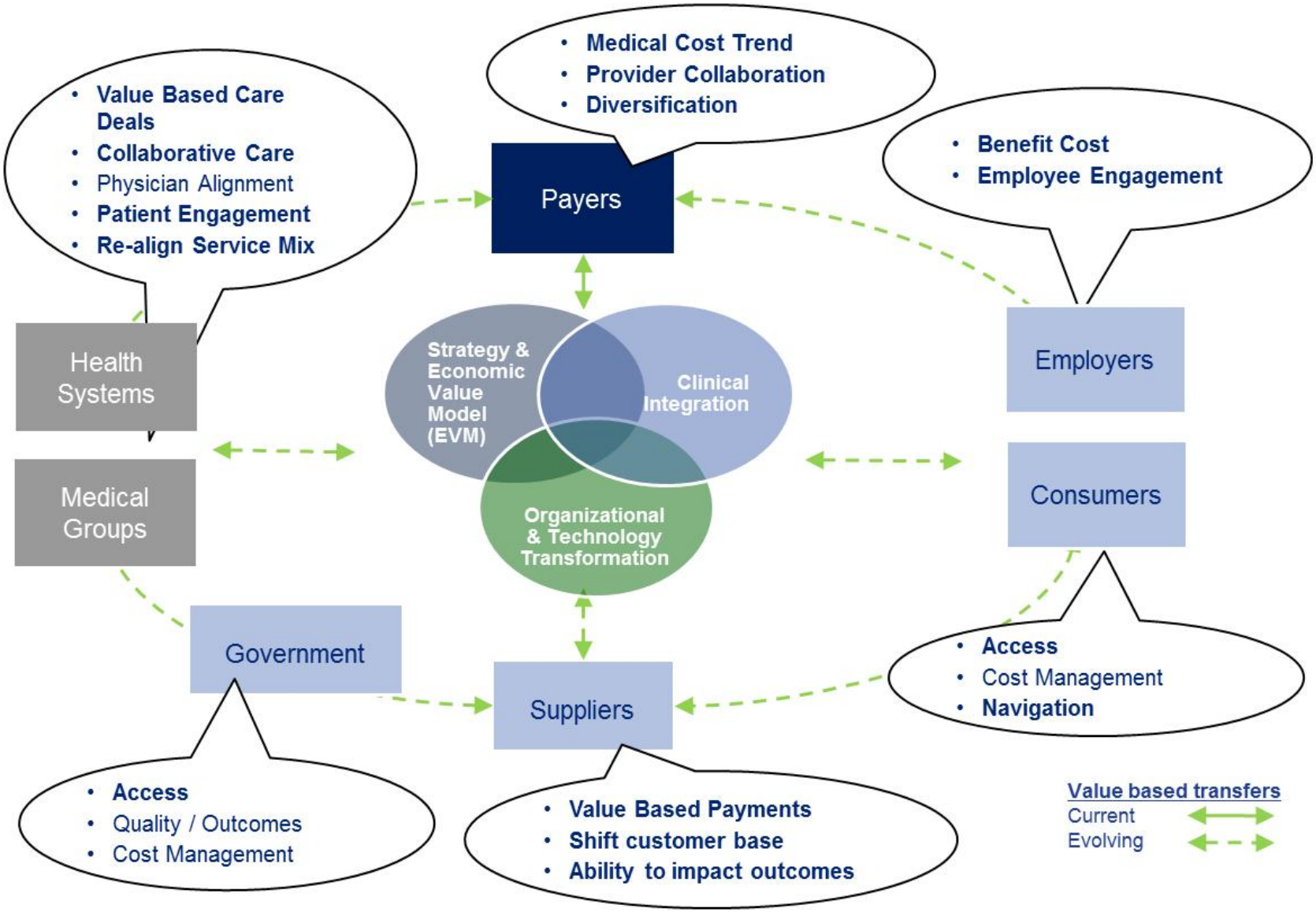
# Chronic Disease Model for Systematic Care Management

The goal of the webinar is to create a foundation of understanding upon which to discuss the role of state health agencies in new care models.




The Wagner Model of Chronic Care was developed by the MacColl Institute.

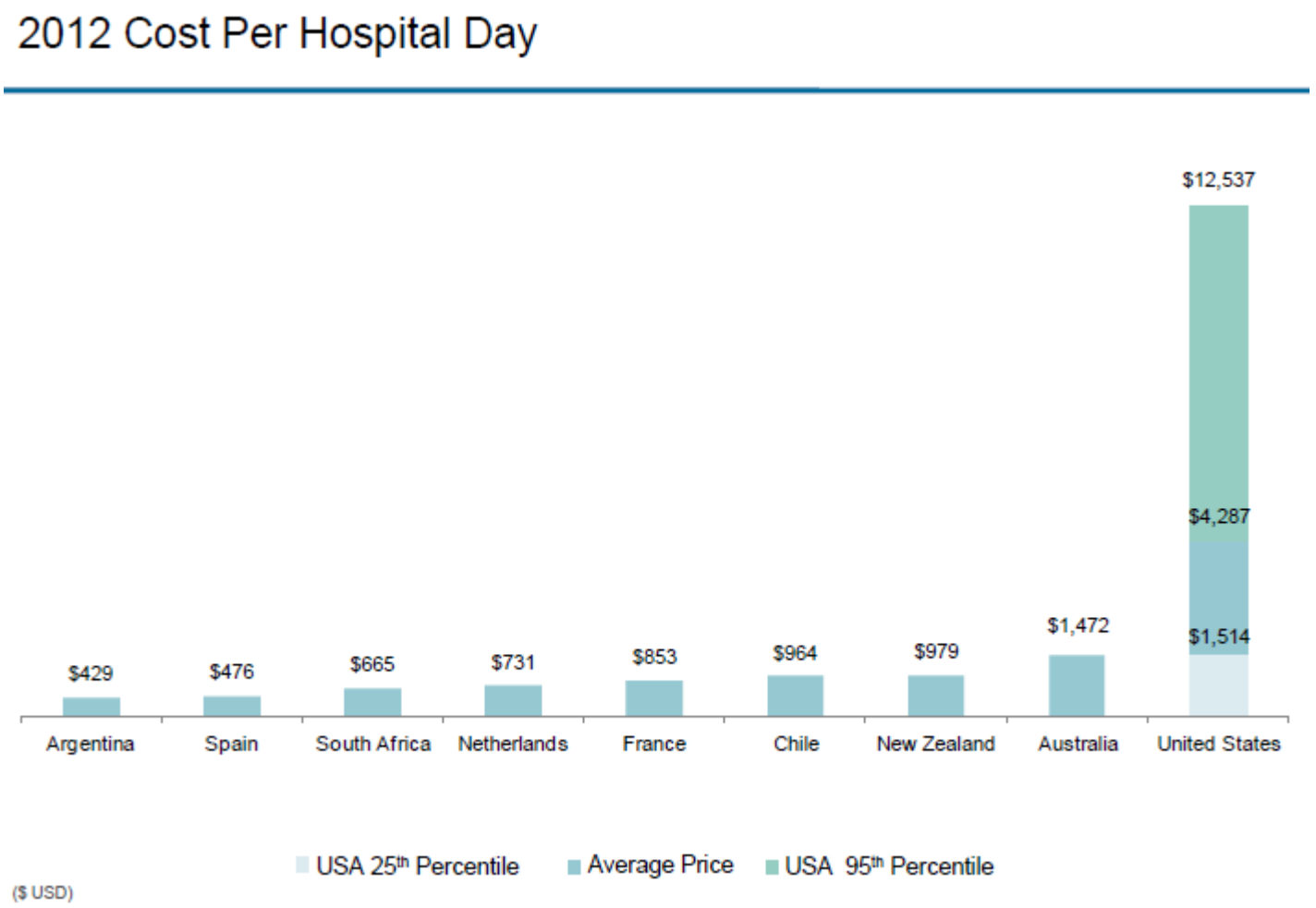
# Current stakeholders face fundamental challenges



# Market Changes – The Need for Value Based Care

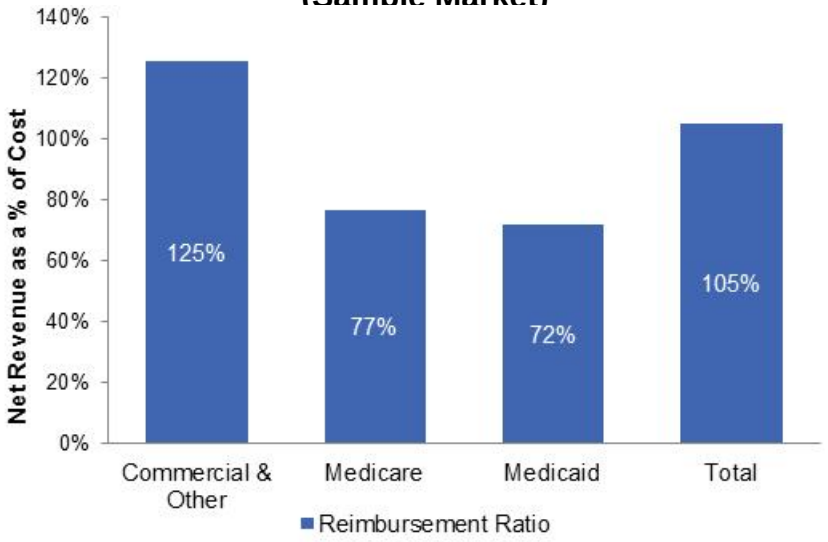
# iFHP/Kaiser Comparative Price Report

US healthcare prices are multiples more than the rest of the industrialized world.

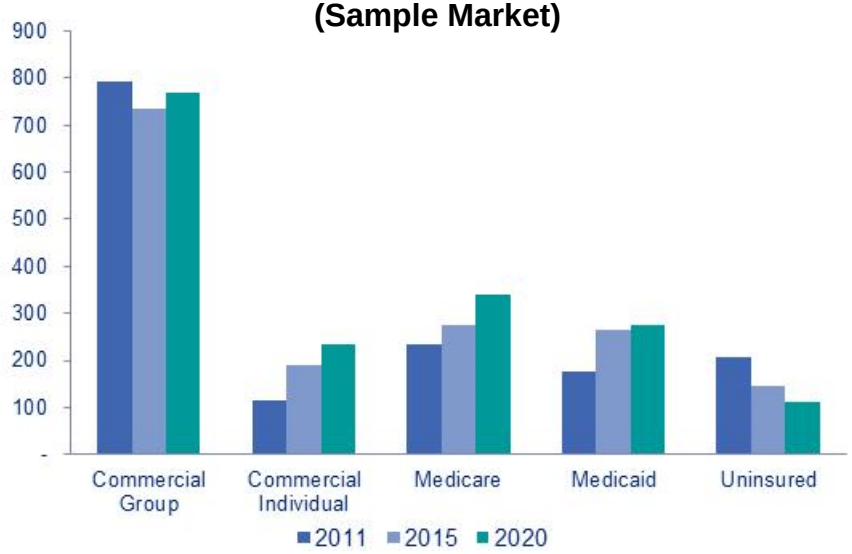


# Looking at the current environment, the status quo is unsustainable

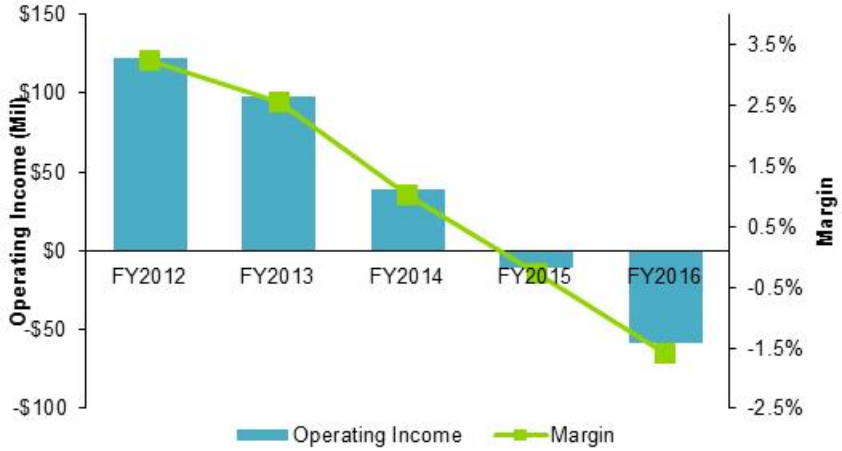
### Provider Revenue as a % of Cost (FY2010)[1] (Sample Market)




### Estimated Enrollment Growth 2011-20[1] (Sample Market)




### Est. Future Margins based on Enrollment Growth[1]




### Key Takeaways

- Continued fee for service (FFS) rate reduction puts pressure on cross subsidization
- Exchanges increase individual enrollment and consumer expectations
- Shift towards segments with lower reimbursement (e.g. Medicare, Medicaid)
- Hospital margins may continue to decline, requiring capture of premium dollar through broader structures, e.g., extended networks, accountable care
- Operational cost reduction may not be sufficient

[1]Based on sample client data and proprietary health reform model

# Market regulatory forces are driving alignment of physicians and hospitals

In many cases, hospitals are providing a “safe harbor” to physicians buffeted by industry forces.

**Industry Drivers**

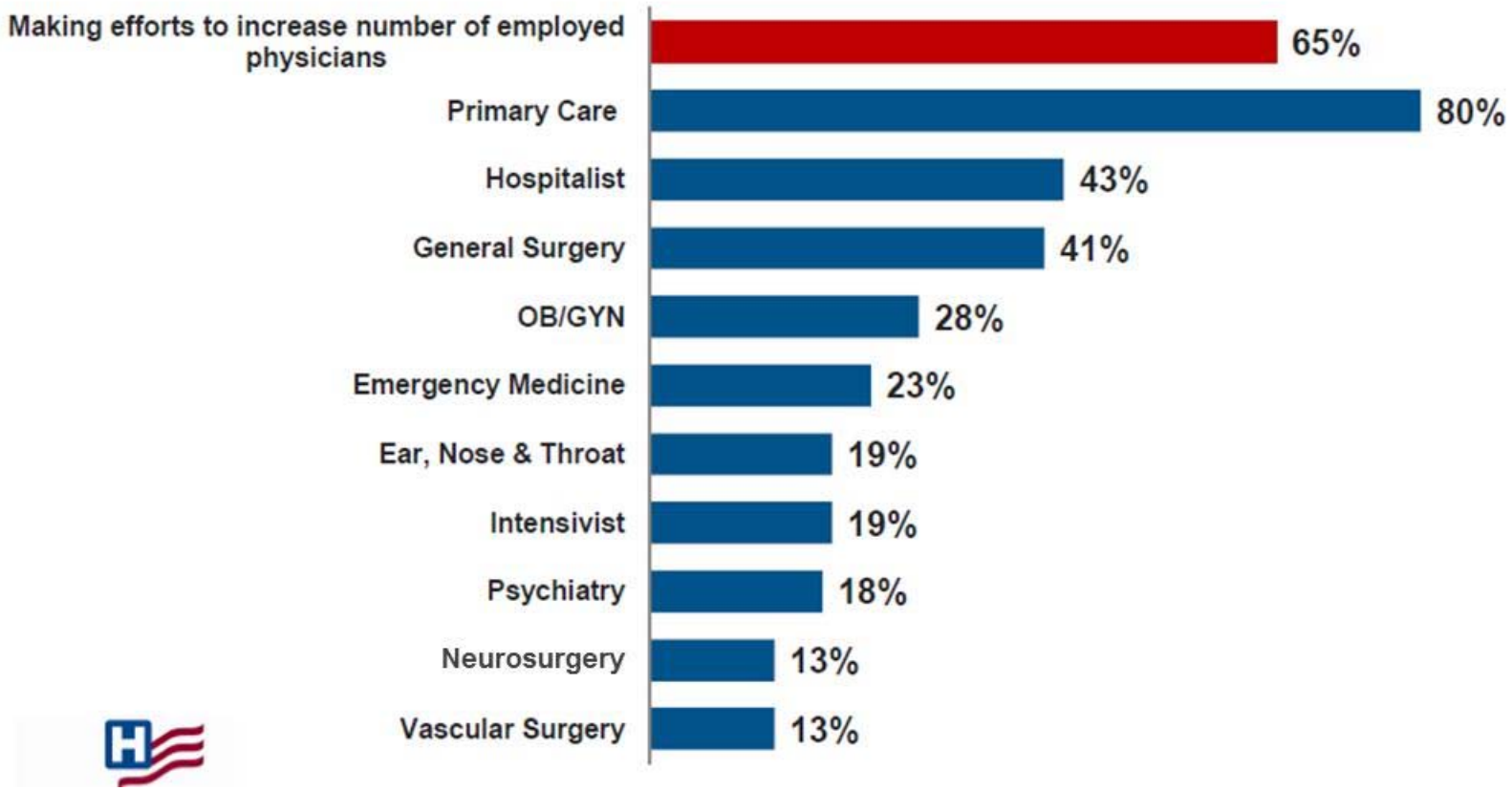
- Pressure on operating margins due to increasing growth in the cost of clinical supplies, malpractice insurance, and labor.
- Growth in the Medicaid and uninsured populations and higher out-of-pocket costs for the insured is leading to a risk of decreased reimbursement.
- Increased emphasis on care coordination in order to take advantage of quality based economic incentives.
- Limited capital availability due to the recession to make major capital investments for electronic health records and infrastructure.
- Changes in Stark law regulations limiting traditional physician and hospital relationships.

**Implications**

The industry drivers will lead to three main models of physician and hospital alignment in the post-Reform environment.

1. Physicians are an individual entity and contract to provide health care services. This is likely in markets where:
   – An existing group is receiving outside capital.
   – Private equity firms are entering into the market to purchase and consolidate physician practices.
2. Physician practices and health systems combine assets to form a new entity, similar to a foundation model. The new entity would be managed similar to a not-for-profit.
3. Hospital is the integrator and utilizes a variety of structures (e.g. physician employment, contracting innovations) in order to align with physicians.

# Hospital-owned physician practices will continue to increase

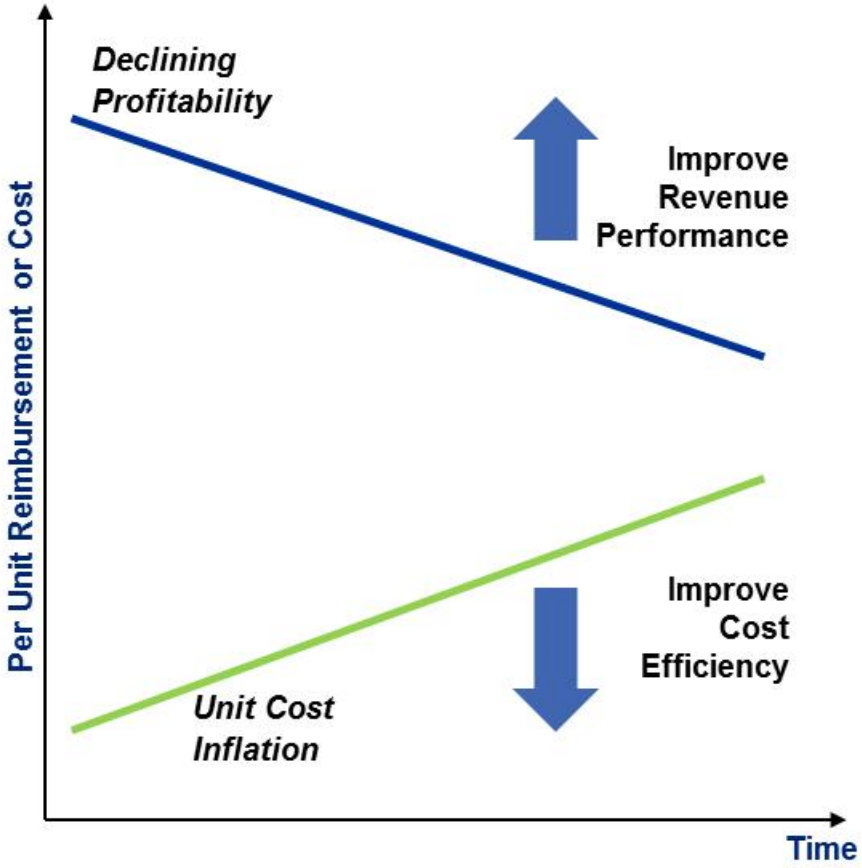



Source: AHA Rapid Response Survey, Telling the Hospital Story Survey, March 2010.

# Durable “Strategic Destinations”

The health system will need to develop a clear value proposition to create market differentiation. In the future, there are likely to be a limited number of paths toward sustainable margin creation.

## Profitability Levers




## Common Strategic Destinations Being Pursued

- ***Deliver superior outcomes/service to realize superior reimbursement (The Innovator)***
- ***Monetize assets/capabilities and extend consumer relationships to achieve a greater ‘share of wallet’ (The Diversifier)***
- ***Use actual and virtual scale to drive a sustainable unit cost advantage (The Aggregator)***
- ***Integrate care across the continuum to decrease utilization and total cost (The Health Care Manager)***

# Strategic “On-Ramps” for taking on performance risk

Provider organizations are pursuing different models to gain experience in risk assumption. These models are substantial transformation efforts as they evolve established ways of delivering care.


[1] Pay for performance, pay for quality, and value based payments

# Provider Marketplace Trends

Assessment of the provider marketplace demonstrates that market is growing even though providers are at different points in their readiness to take on value-based care (VBC).

| | Haven't Started | Evaluating Options | Taking on Risk | Already Transformed |
|---|---|---|---|---|
| **Description** | Have resisted change; May be due to limited market demand, a lack of ability or resources to begin, or uncertainty of future | Beginning to consider opportunities to prepare for VBC and taking small first steps to initiate change | Have taken initial steps in taking on risk and have a high level plan to shift towards VBC | Integrated delivery system that have been functioning as an VBC-type entity |
| **Sample Geographies** | South-East | TX, NE, CO, AZ | IL, MA, MI | SoCal, WA, Twin-Cities |
| **Examples** | ▪ Rest of the market | ▪ Orlando Health<br>▪ Seton<br>▪ Baylor Health<br>▪ Carillion | ▪ Tucson Medical Center<br>▪ Banner Health | ▪ Dean Health<br>▪ Intermountain<br>▪ Geisinger<br>▪ Kaiser |
| **% of Hospital Market** | *25%* | *50%* | *20%* | *5%* |

***Level of VBC Readiness***

Source: Leavitt Group, Healthleaders Media Industry Survey 2012 .

# Accountable Care Organizations (ACOs)

# Accountable Care Solution Goals and Hallmarks

| Accountable Care Solution Goals |
| --- |
| **Drive the transformation** to a patient-centered care model that promotes **access**, **coordination** across the continuum, **wellness** and **prevention** by **collaborating** with physicians, **starting with primary care**, in ways that allows them to **successfully manage the health of their patients** and **thrive in a value-based reimbursement** environment |

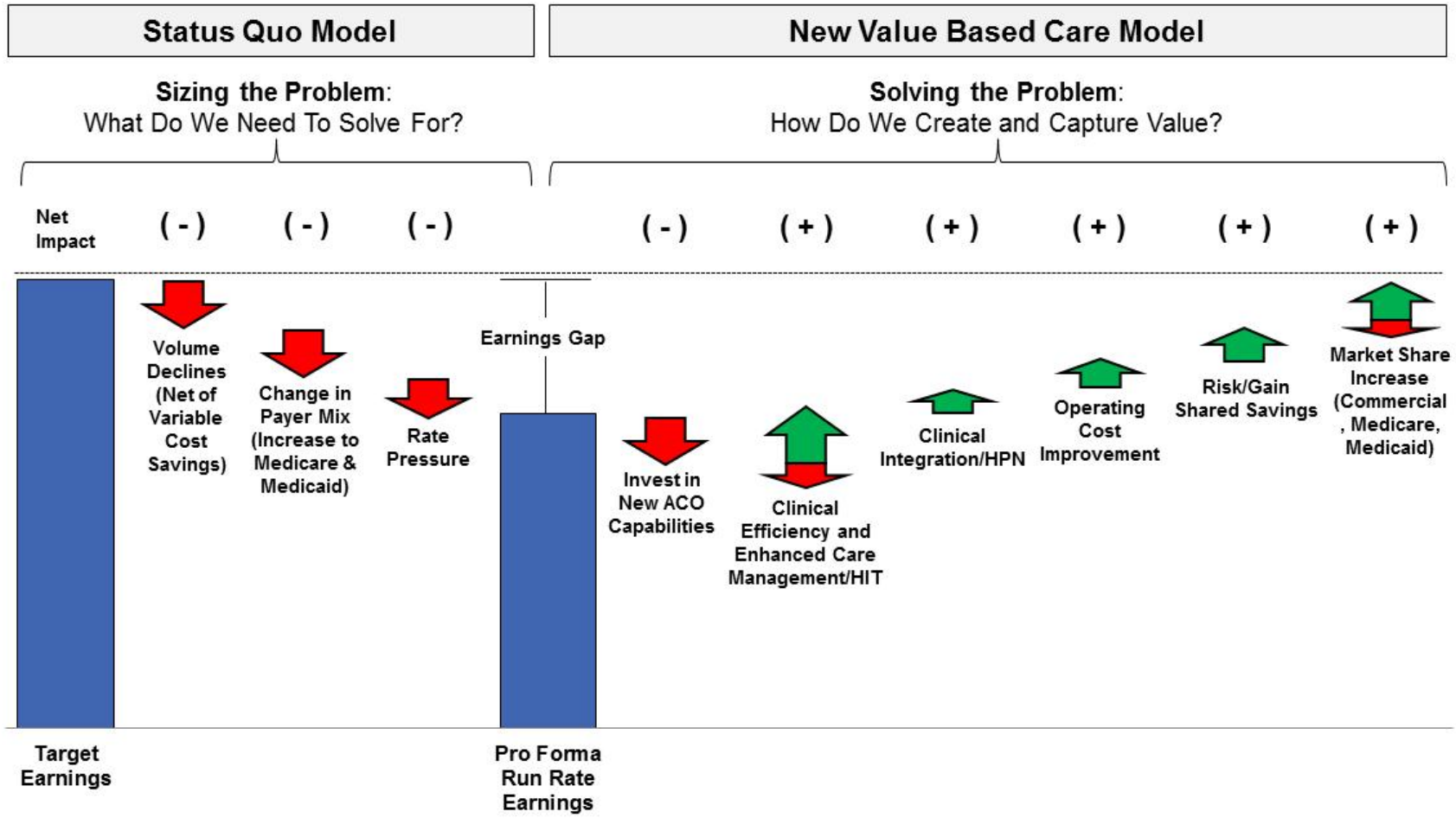
## Hallmarks of Accountable Care Solution

- **Support for high risk patients**
- **Coordination of care across the delivery system**
- **Facilitated and ensured access**
- **Shared decision-making and accountability with patients and their caregivers**
- **Promotion of wellness and prevention**
- **Outcomes and compliance with evidence-based guidelines is measured and monitored**

**The hallmarks of patient-centered care solution align with how of 'Accountable Care Organizations' have been defined by the industry.**

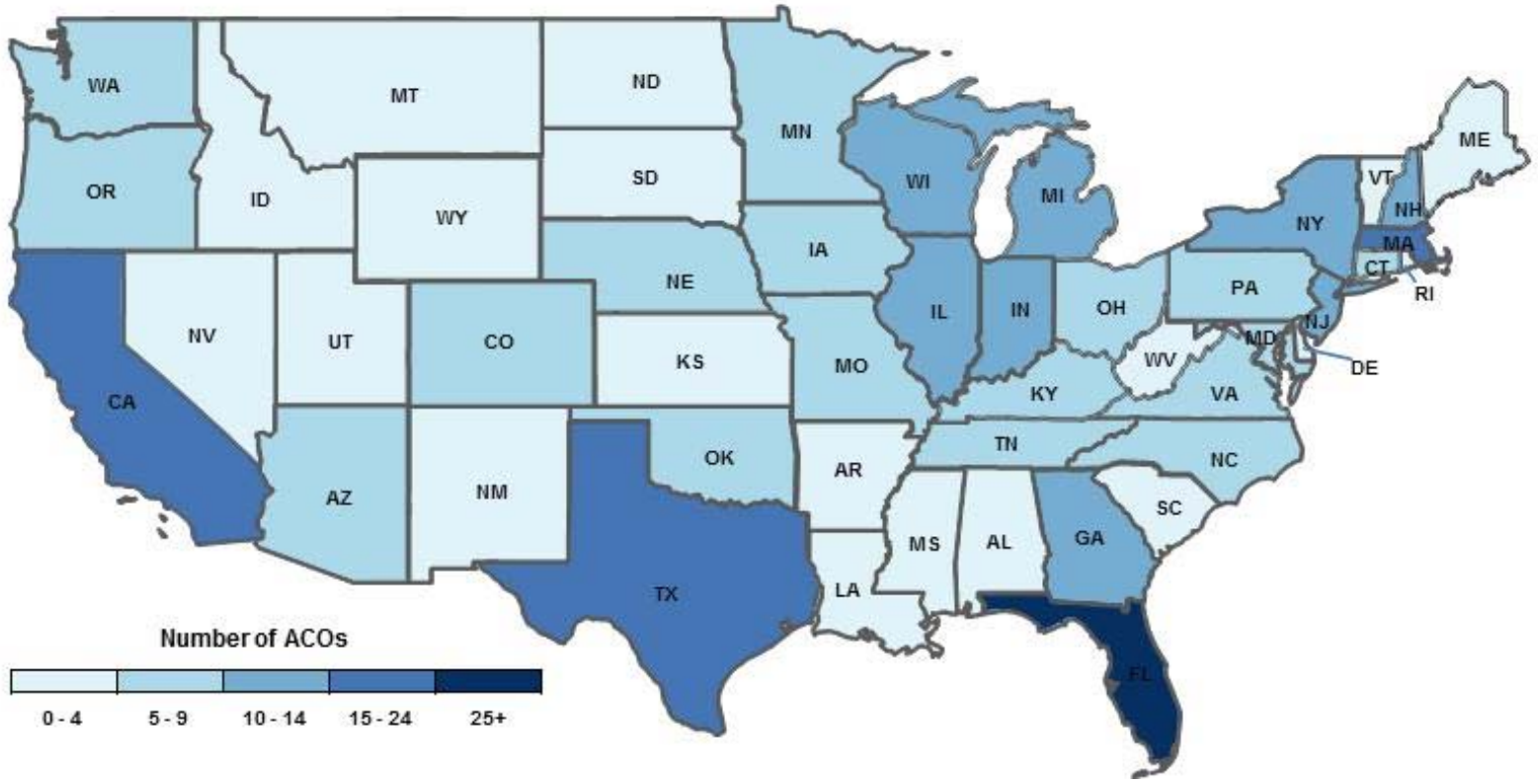
# Projecting Financial Impact of Performance Risk

ACO models offer a strong long-term value proposition.



# Number of ACO Entities[1]

The number of entities is growing with every Centers for Medicare & Medicaid Services ACO release.




[1]Based on March 2013 data

# Total Number of ACO Entities by State/Territory[1]

| State/Territory | ACO Entities # |
|---|---|
| Alabama | 1 |
| Alaska | 0 |
| Arizona | 6 |
| Arkansas | 3 |
| California | 22 |
| Colorado | 7 |
| Connecticut | 9 |
| Delaware | 1 |
| Florida | 29 |
| Georgia | 12 |
| Hawaii | 0 |
| Idaho | 1 |
| Illinois | 10 |
| Indiana | 10 |
| Iowa | 7 |
| Kansas | 1 |
| Kentucky | 7 |
| Louisiana | 1 |

| State/Territory | ACO Entities # |
|---|---|
| Maine | 3 |
| Maryland | 9 |
| Massachusetts | 18 |
| Michigan | 6 |
| Minnesota | 6 |
| Mississippi | 2 |
| Missouri | 5 |
| Montana | 1 |
| Nebraska | 3 |
| Nevada | 2 |
| New Hampshire | 8 |
| New Jersey | 10 |
| New Mexico | 3 |
| New York | 12 |
| North Carolina | 6 |
| North Dakota | 0 |
| Ohio | 9 |
| Oklahoma | 1 |

| State/Territory | ACO Entities # |
|---|---|
| Oregon | 2 |
| Pennsylvania | 5 |
| Puerto Rico | 2 |
| Rhode Island | 2 |
| South Carolina | 3 |
| South Dakota | 0 |
| Tennessee | 7 |
| Texas | 17 |
| Utah | 2 |
| Vermont | 4 |
| Virginia | 6 |
| Washington | 1 |
| Washington, DC | 2 |
| West Virginia | 0 |
| Wisconsin | 7 |
| Wyoming | 1 |

[1]Based on March 2013 data

# Value Based Care (VBC) Models

Providers continue to implement varying types of VBC models to drive clinical integration and performance risk.

**Models for Providing Value Based Care**

| Medicare MSSP Model | Employee Model | Payer / Provider Partnerships | Expanded Risk Models | Comprehensive / Global |
|---|---|---|---|---|

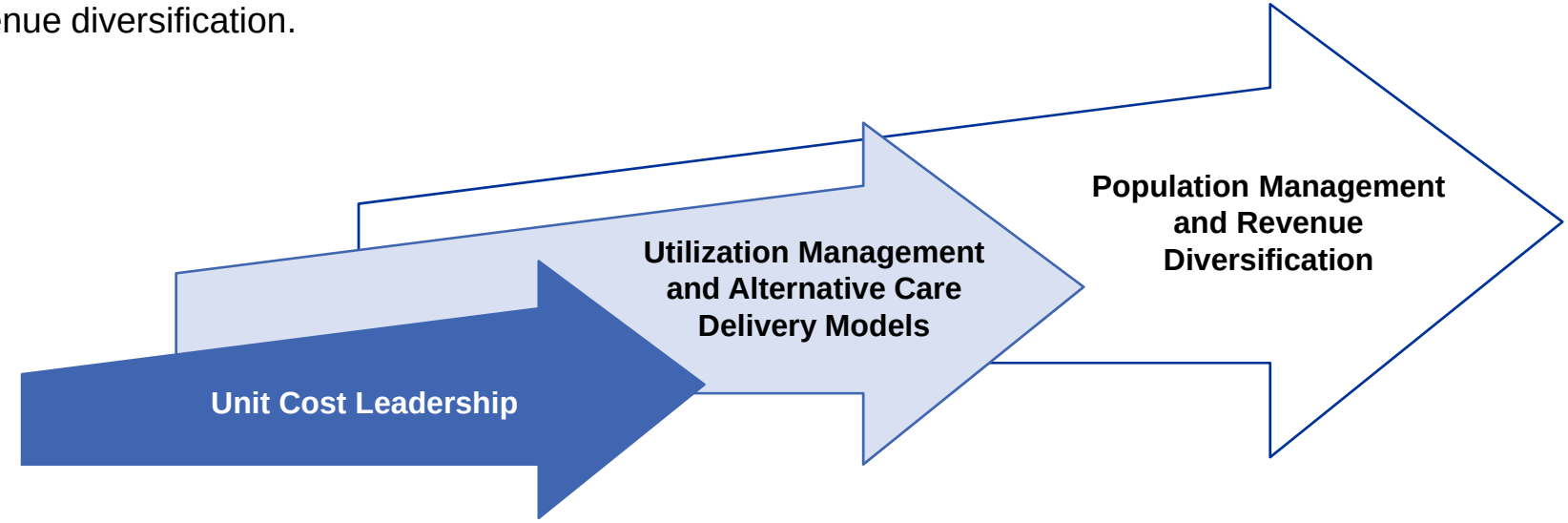
**Degree of Risk and Clinical Integration**

Low — High

| Description of Models | | | | |
|---|---|---|---|---|
| ▪ Low downside option<br>▪ Largely Fee for Service model with a layer of Pay for Performance<br>▪ Shared savings / bonuses for clinical process driven improvements and defined measures of clinical metrics | ▪ Many of the hospitals are starting with Provider Employee models<br>▪ Hospital employers taking on risk with their own employees<br>▪ Low expected level of risk, due to controlled population but typical high utilization (10-15%) | ▪ A single payer and multiple providers develop relationship that carries partial risk<br>▪ Requires realignment within a limited population or care delivery innovation (e.g. PCMH models)<br>▪ Could begin with limited risk and can expand to limited gain sharing | ▪ Existing provider risk-bearing entities looking to expand risk pool<br>▪ Better understanding and expectation of actuarial and financial risk-taking needed<br>▪ Expanded clinical and population management strategies | ▪ A comprehensive and full risk model for a large population<br>▪ Could include participation of multiple payers and multiple providers<br>▪ Includes Integrated Delivery System |
| **Market Examples** | | | | |
| ▪ 189 MSSP (Hospitals and Physician Groups)<br>▪ Pioneer ACO's | ▪ Seton, SLHS Idaho, Banner Health | ▪ Cigna and 50 other Care Coordination Groups<br>▪ Scott and White HealthCare<br>▪ Aetna / Optimus HC | ▪ Tucson Arizona | ▪ Intermountain, Kaiser, Dean Health System |

# Key Components of VBC Strategy

VBC strategies typically have one or more components: cost leadership, utilization management, and/or revenue diversification.




| Unit Cost Leadership | Utilization Management and Alternative Care Delivery Models | Population Management and Revenue Diversification |
|---|---|---|
| Use scale and select partnerships to lower the cost of service, while maintaining superior quality | Utilize integration to improve health, reduce need for care / use of expensive resources, and assume risk for delivering value based care | Leverage brand, reputation and relationships to extend into new products and services |
| ▪ Top quartile performance in unit cost and quality<br>▪ Profitable at/close to Medicare reimbursement | ▪ Expanding care continuum<br>▪ Implementing new programs to improve costs and revenue performance | ▪ Revenue base shifting towards global/fixed payments over time<br>▪ Developing relationships with new customers/segments |

# VBC Capabilities

Successful VBC models will require strong capabilities in six critical areas.

## Leadership and Governance

- Governance system of accountability
- Physician leadership decision-making rights and responsibilities
- Performance measures to inform clinical and business decisions
- Communications and change management approach

## Information and Integration Services

- Clinical information systems
- Data warehouses
- Analytics and business intelligence
- Interoperability and data sharing
- Population health reporting
- Secured health information

## Clinical Integration

- Care coordination and transition processes
- Clinical protocols and guidelines
- Tools/processes to support integration and care coordination
- Quality, safety, and outcomes
- Population health management/ care management/ disease management (vs. case management)
- Patient engagement/satisfaction

## Network and Physician Alignment

- High value network composition
- Physician alignment
- Community/public health programs and services engagement
- Provider evaluation and performance metrics
- Quality and performance reporting

## Business Operations

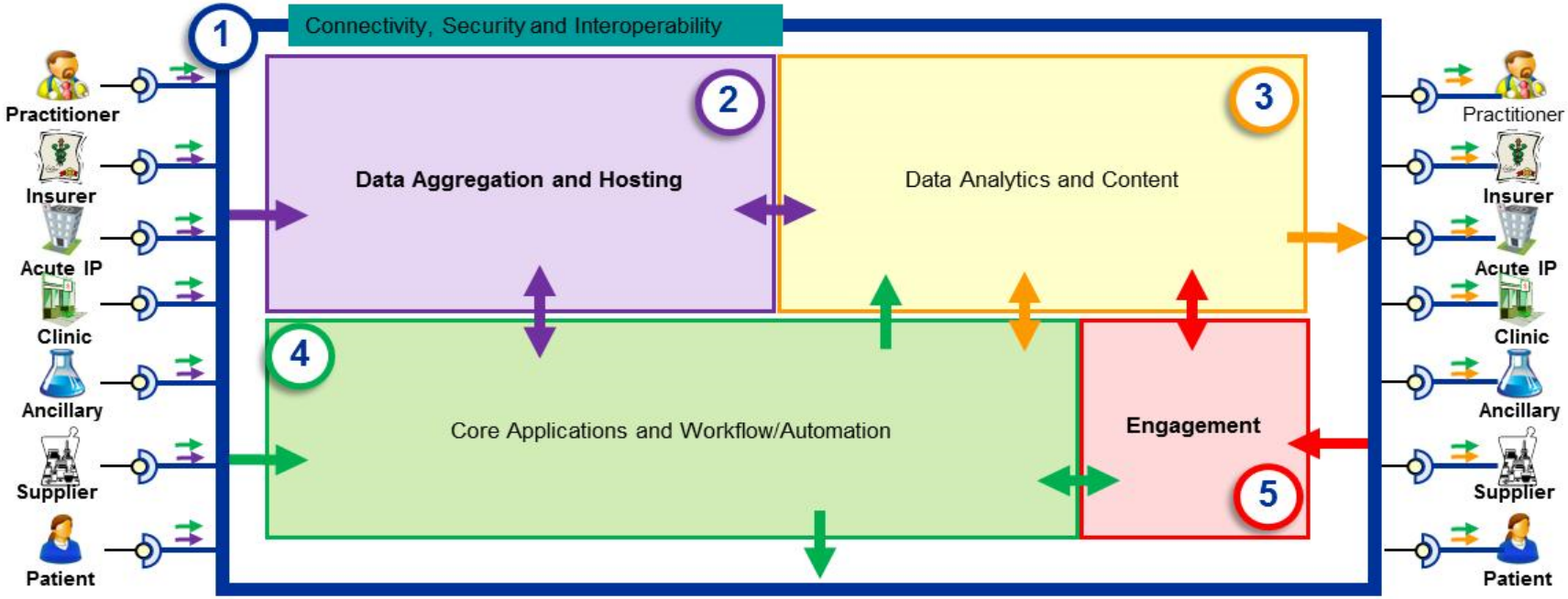
- Process standardization
- Service operations
- Customer relationships
- Rating and underwriting
- Performance improvement
- Resource management
- Cost management
- Marketing and sales
- Legal and compliance
- Revenue cycle

## Incentive Alignment

- Economic model
- Value-based risk arrangements
- Distribution model
- Compensation and incentives
- Third-party agreements

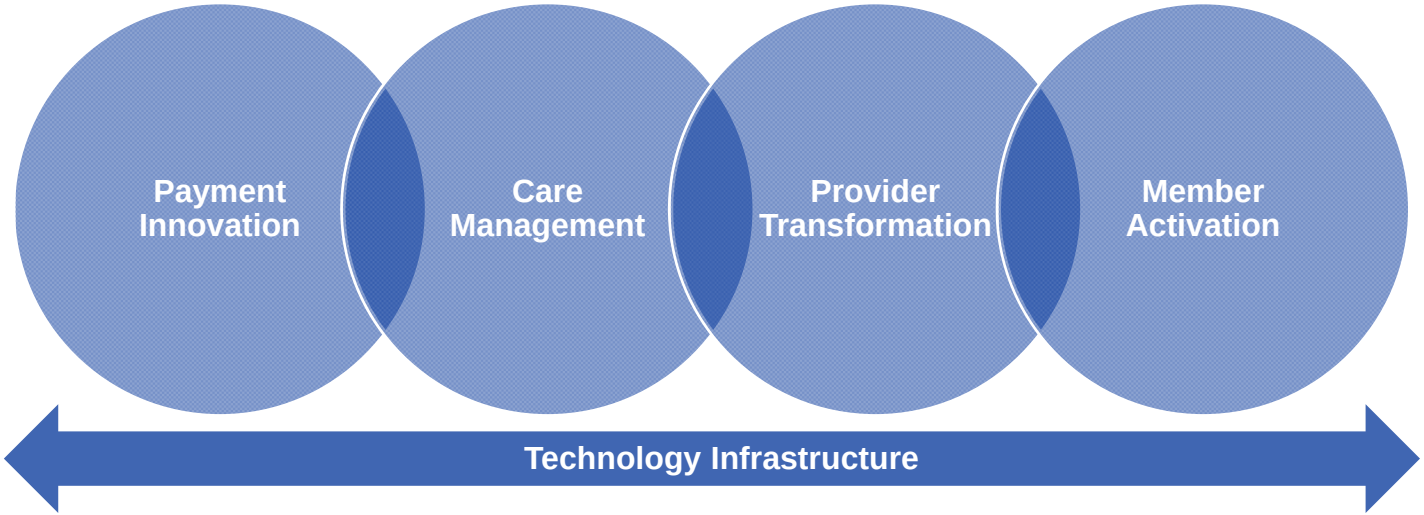
# Conceptual IT Architecture

Health care is focused on acquiring clinical data and facilitating provider care management workflow.




1. Connectivity, Security and Interoperability: Connects to all the data producers, provides access to data consumers, and validates access rights.
2. Data Aggregation and Hosting: Retrieve data from the data producers and transform it to fit the meta-data storing structure.
3. Data Analytics and Content: Using self-actualizing trends and business solution-specific heuristics, analyzes transactional data, and creates enriched information. Data delivery occurs via screen-reports and services/API.
4. Core Applications and Workflow/Automation: Orchestrates the execution of activities that constitutes the care continuum, gathering contextual information from both the transactional systems as well as the data warehouse.
5. Engagement: Key interfaces for both patients and physicians to facilitate their interactions with the VBC system, leveraging workflow and analytics to enhance engagement and satisfaction for both these stakeholders.

# Key Solution Components that Drive a Shift to Accountable Care




**Payment Innovation**

- Moving from volume to value-based payment models

**Care Management**

- Promoting ensured access and proactive longitudinal population health care built around the needs of the patient

**Provider Transformation**

- Giving providers the information, tools, and resources they need to move towards a proactive, coordinated, population health model

**Member Activation**

- Engaging attributed members as active participants in the model and encouraging the establishment of a relationship with a trusted provider

**Technology Infrastructure**

- Creating the information and work flow tools that will enable the transformation for all constituents across the continuum

# Patient-Centered Medical Homes

## What exactly is a Patient-Centered Medical Home (PCMH)?

A patient-centered medical home integrates patients as active participants in their own health and well-being. Patients are cared for by a physician who leads the medical team that coordinates all aspects of preventive, acute and chronic needs of patients using the best available evidence and appropriate technology. These relationships offer patients comfort, convenience, and optimal health throughout their lifetimes.

Source: http://www.aafp.org/practice-management/pcmh/overview.html

# PCMH Model

A PCMH requires a comprehensive approach.

## Patient Provider Relationships

- Patient-related tools (education and awareness) developed and distributed
- Trained staff
- Signed agreement or documented patient communication to establish relationship
- Systematic notification to patients about partnerships

## Patient Registry

- Paper or electronic
- Clinical Information – manage all established patients in practice unit classified by disease, regardless of insurance coverage
- Incorporates evidence-based care guidelines
- Available and in use at point of care (data from EMR)
- Used to flag gaps in care

## Performance Reporting

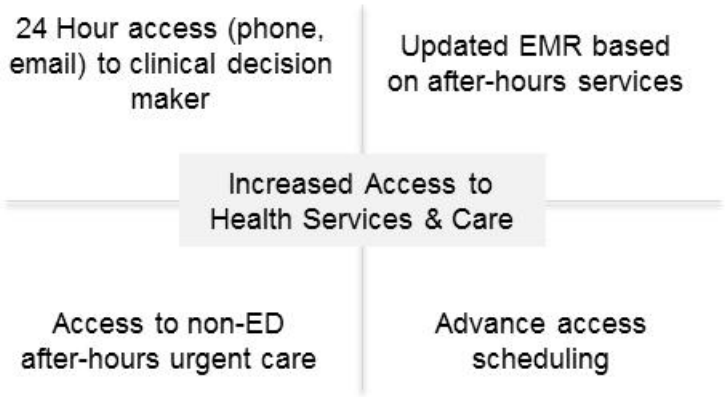
- Allows tracking and comparison of results at a specific point in time across the population for a specific disease
- Systematic, routine, aggregate-level reports with current, clinically meaningful data on patients in registry
- Actively analyzed in provider self-assessment
- Population-level, practice unit and provider-level reports
- Validated and reconciled for accuracy
- Trend reports to manage changes over time

## Individual Care Management

- Practice unit leaders and staff have been trained/educated on PCMH concepts
- Team of multidisciplinary providers
- Several nonphysician members, including RN
- Evidence-based care guidelines in place
- Strategic action plan and goal setting for all patients with a chronic condition

# PCMH Model – Additional Information

## Extended Access




## Linkage to Community Service

- Provider office conducts comprehensive review of community resources for population that they serve
- Community resource database
- Established collaborative relationships with community-based organizations
- Practice unit team trained on available resources for accurate referrals

## Preventive Services

***Primary Prevention Program***

- Identify and educate patients about personal health behaviors to reduce risk of injury and disease
- Systematic approach to provide preventive care and services according to preventive care guidelines
- Strategies to promote and conduct outreach regarding ongoing well-care visits and screenings
- Reminder system in place for preventive care screenings
- Incorporate patient's outside health encounters into patient record
- Written standing order protocols allowing practice unit care team members to authorize and deliver preventive services according to physician-approved protocol without examination by a clinician

# PCMH Model – Additional Information (cont.)

## Self Management Support

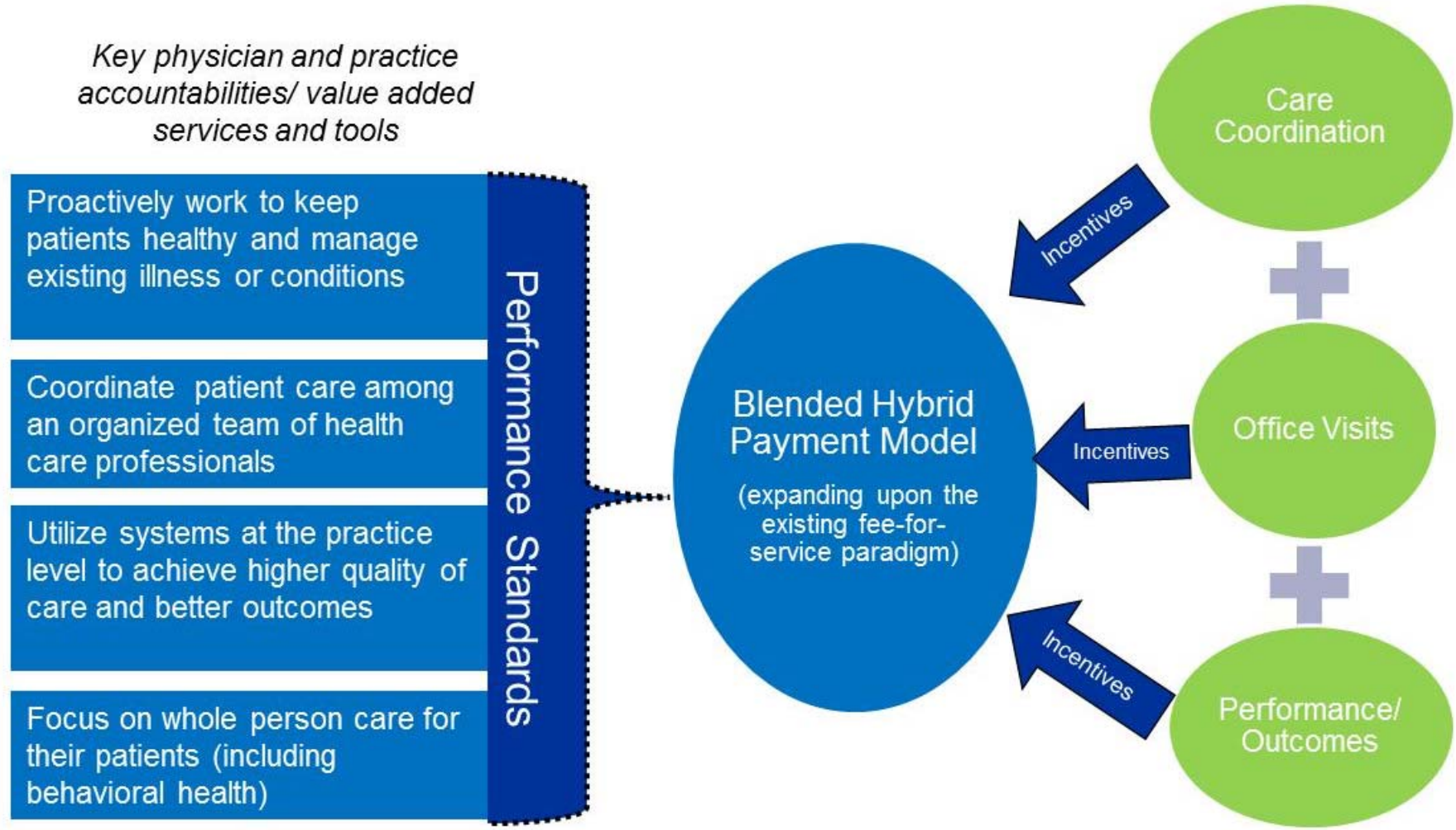
*Systematic approach to empowering the patient with chronic illness*

- Clinical team familiar with and trained on self-management concepts and techniques
- Offered to all patients with the chronic condition selected for initial focus (based on need, suitability, and patient interest)
- Follow up for chronic care patients engaged in self-management support
- Regular patient experience surveys

| Patient Web Portal | Coordination of Care | Specialist Referral |
|---|---|---|
| • Facilitates **two-way communication** between patient and provider<br>• Patients can request and schedule appointments<br>• **E-visits** for patients | • **Provider notification** for patient admit, discharge or other services<br>• Process for **exchanging medical records** and discussing care with other providers | • **Separate guidelines** for PCP offices and specialist offices<br>• Guidelines for timeframes for appointments and information exchange |
| • Patients able to log self-administered tests and view results of provider-given tests<br>• **Alerts to providers** regarding potential health issue based on self-reported patient data | • Track care coordination activities for patients with chronic conditions<br>• **Flag patient issues** requiring immediate attention<br>• Transition plans between caregivers | • Directory of routinely referred specialists<br>• Practice unit makes specialist appointment on behalf of patient<br>• **Electronic tools to avoid duplication** of testing and prescribing |

# PCPCC Payment Model

A blended payment model will be determined by the quality of care provided and how physicians and practices meet performance standards



# Reported Outcomes

Preliminary research has demonstrated the quality of care and cost improvements resulting from PCMH programs.

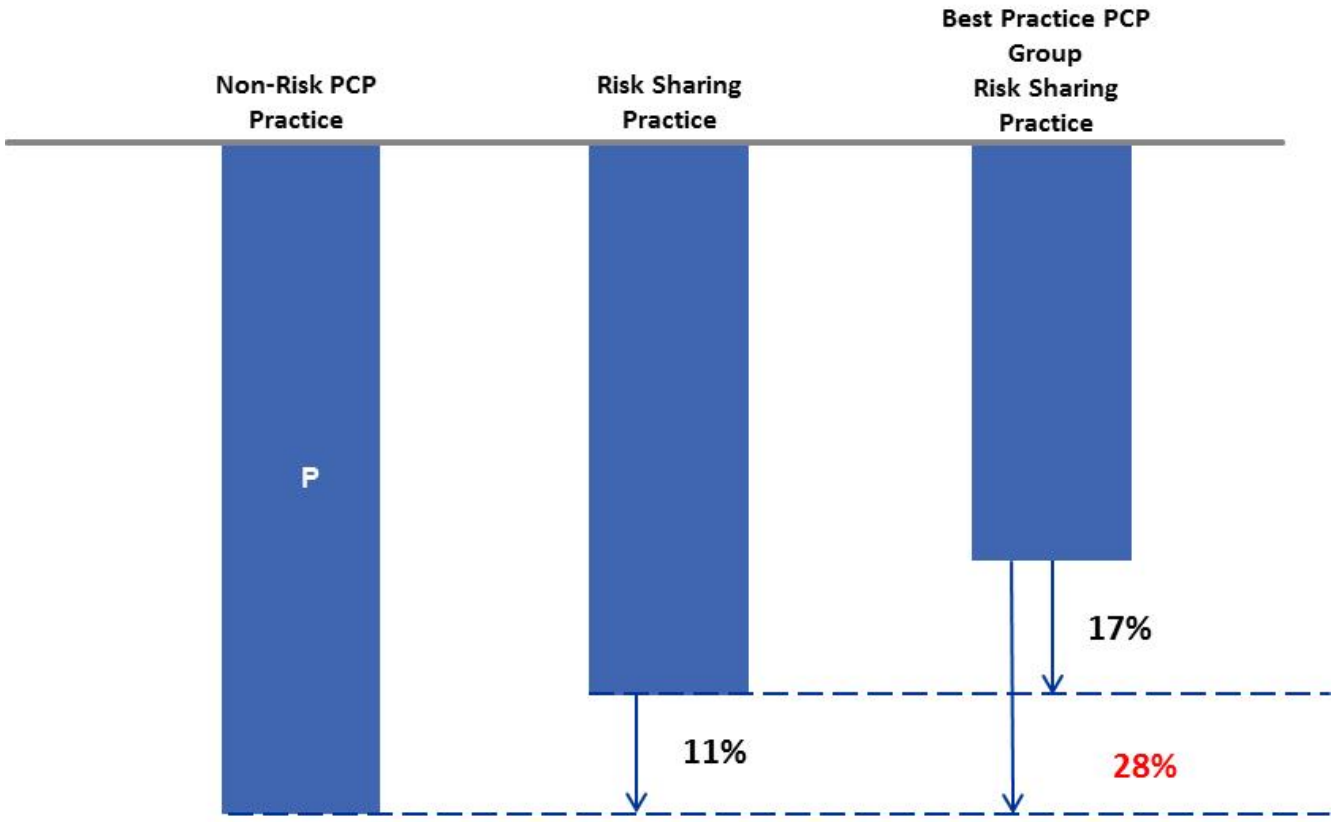
| PCMH Site and Outcome | |
|---|---|
| Group Health Cooperative of Puget Sound | • 29% reduction in ER visits<br>• 16% reduction in hospital admissions<br>• Reduced costs |
| Geisinger Health System | • 18% decrease in hospital admissions<br>• Improvements in diabetes and heart disease care<br>• 7% reduction in costs |
| Veterans Health Administration | • Improved Chronic Disease treatments<br>• 27% reduction in ER visits & hospitalizations<br>• Lower median costs for veterans with chronic conditions |
| Health Partners Medical Group MN | • 39% decrease in ER visits<br>• 24% decrease in hospital admissions<br>• Enrollment cost reduced to 92% of the state average |
| Intermountain Healthcare Medical Group Care Management Plus | • 39% decrease in emergency room admissions<br>• 24% decrease in hospital admissions<br>• Net reduction cost of $640 pp and $1,650 for high risk patients |
| Blue Cross Blue Shield of SC – Palmetto Primary Care Physician | • 12.4% decrease in ER visits<br>• 10% decrease in hospital admissions<br>• Total medical and pharmacy costs were 6.5% lower |
| Medicaid Sponsored PCMH Initaitives | • NC: $974.5m savings over 6 yrs & 16% lower ER visits<br>• CO: PCMH Children's annual median cost was $2,275 compared to those not enrolled $3,404 |
| Miscellaneous PCMH Programs | • John Hopkins: 24% reduction in total Inpatient days<br>• Genesee MI:50% reduction in ER visits<br>• Erie County: Organizational savings of $1m/1000 enrollees |

Source: PCPCC Pilot Guide, 2010.

# Medicare PCMH Medical Cost Performance

Provider-based contracts managed inpatient (and readmissions) more effectively and was the main source of savings even as OP and professional costs rose slightly.

**Comparison of PCMH Medical Cost Components Medicare Advantage Program**




***The performance gap represented over $200M in medical costs for the population managed.***

# Physician Group Performance to Best Practice Model

The infrastructure that supports the provider model has a strong (but not exact) correlation and financial performance.

| | D | B | F | E | G | C | A1 | A2 |
|---|---|---|---|---|---|---|---|---|
| Membership | 6,687 | 14,038 | 3,408 | 4,134 | 2,441 | 9,358 | 17,759 | 4,705 |
| Incentives (Transparency) |  |  |  |  |  |  |  |  |
| Physician Leadership |  |  |  |  |  |  |  |  |
| Care Management – In Patient |  |  |  |  |  |  |  |  |
| Care Management – Ambulatory |  |  |  |  |  |  |  |  |
| Reporting (collaboration) |  |  |  |  |  |  |  |  |
| PMPM performance against benchmark* | $127.23 | $29.90 | $22.55 | $14.14 | ($5.82) | ($6.51) | ($13.60) | ($15.38) |

** Based on the Northeast lightly managed MA external benchmark; a **negative** value indicates **poor** performance (opportunity for improvement)*

***KEY:***  Leading  Advanced  Established  Emerging

# Overview of Minnesota Experience

Ellen Benavides, MHA
Assistant Commissioner, Minnesota Department of Health

# Overview of Massachusetts Experience

John Auerbach, MBA
Director, Institute on Urban Health Research and Practice

# Questions

Deloitte.



Member of
Deloitte Touche Tohmatsu