Aligning for Action

LAN SUMMIT

Health Care Payment Learning & Action Network

Succeeding with APMs: Structuring Relationships Between Payers and Providers

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Welcome

Mara McDermott (CAPG)

Vice President,
Federal Affairs, CAPG

Today's Panel

Christy Mokrohisky

Vice President, Population Health Management, St. Joseph Heritage Healthcare

Kersten Kraft

Director, Representing Santa Clara County Individual Practice Association at California Association of Physician Groups

Nicholas Gettas

Senior Vice President and Chief Medical Officer of CareAllies

David Kerwar

Head of ACO Enablement Solutions at Aetna's Accountable Care Solutions

About CAPG

- Professional association representing medical groups and IPAs in 44 states, DC and Puerto Rico

- Our groups participate in broad range of alternative payment models

CAPG's Guide to Alternative Payment Models

- Bundled payments
- Next Gen ACO
- Managed fee for service: Medicare Advantage
- Global Risk: Medicaid Managed Care
- Subcapitation: MA and Commercial
- Commercial Pay for Performance

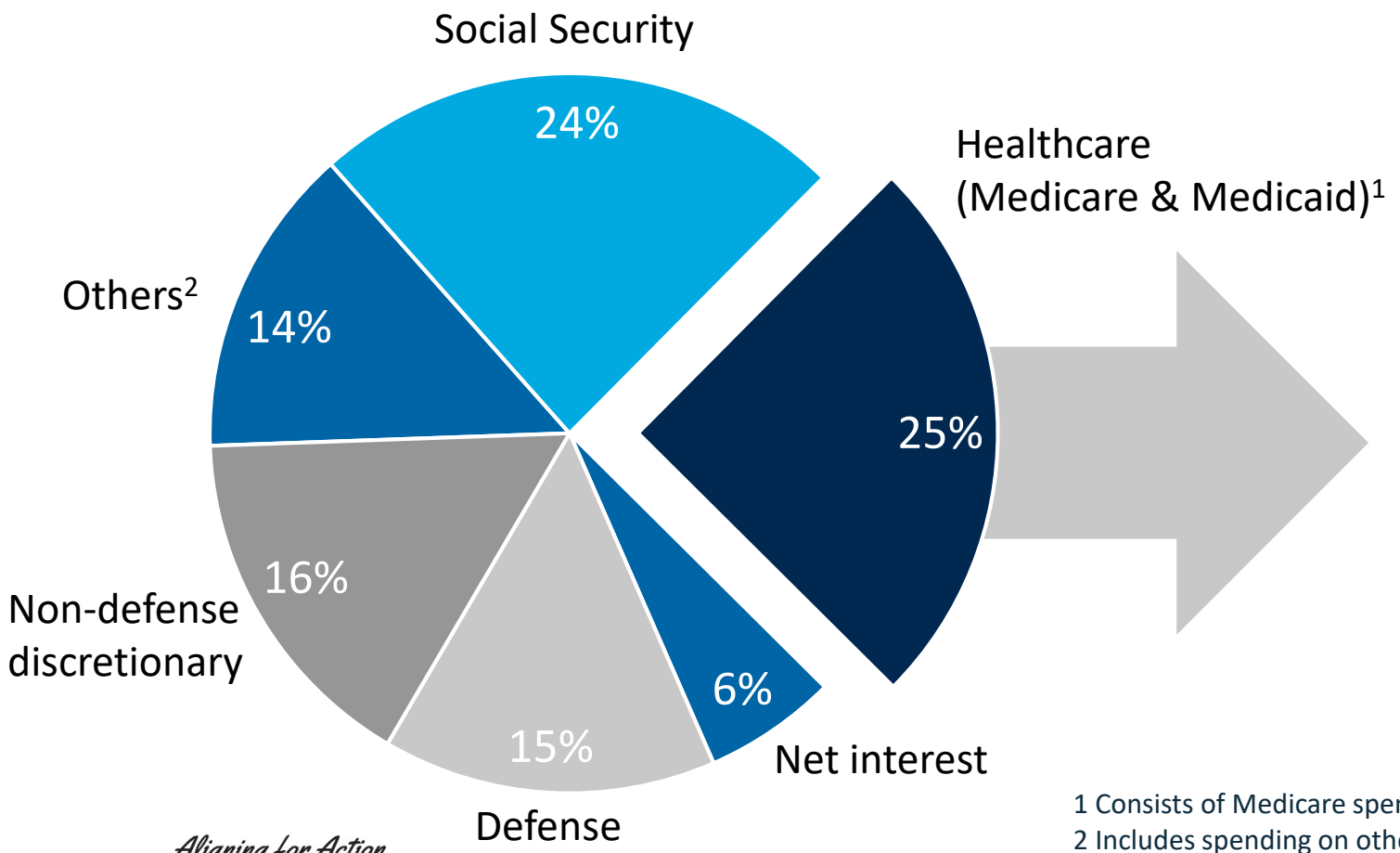
Nick Gettas, MD

Chief Medical Officer, CareAllies

Healthcare spending and the shift to value

US Federal Spending – Fiscal Year 2016

$ Total $3.9 Trillion



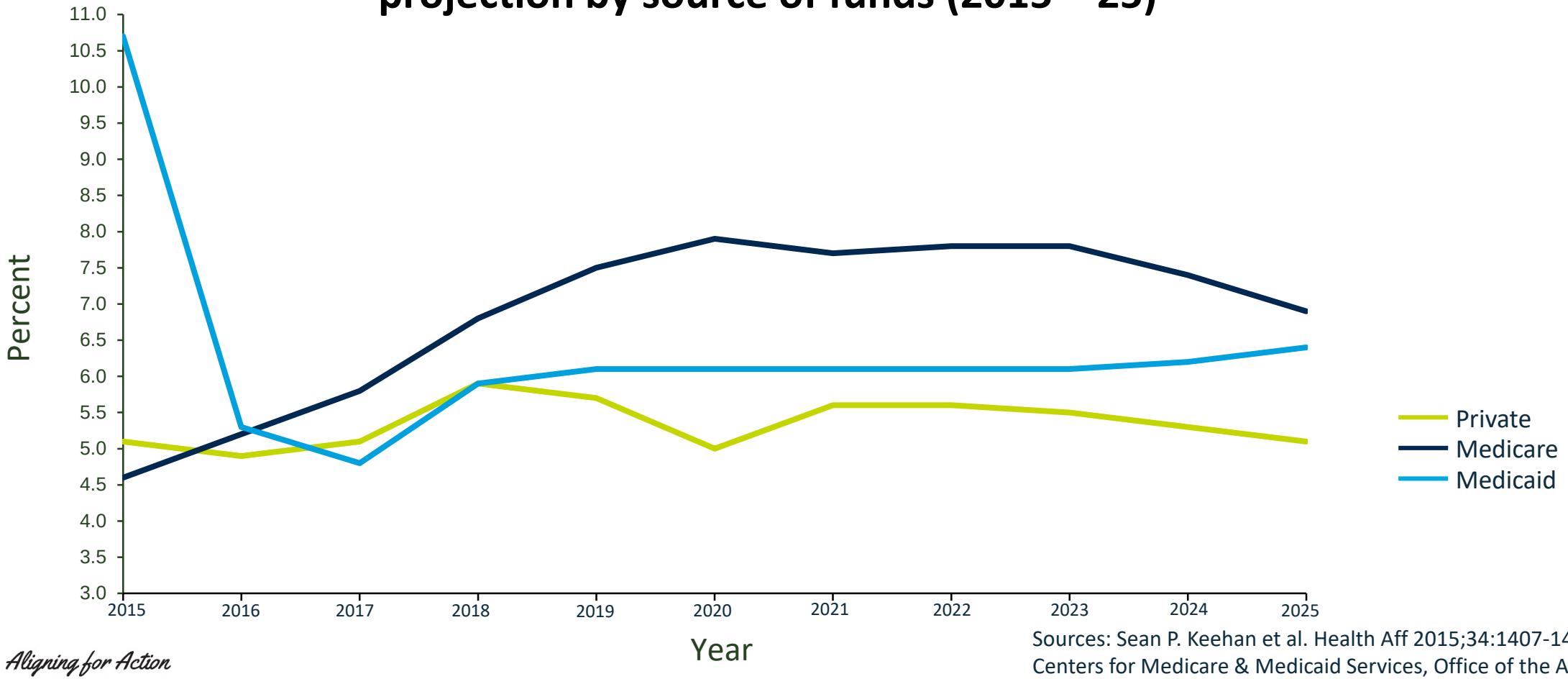
Driving a shift to value

- Federal deficit and state budgets
- Quality gap per dollar spent
- Long-term federal financing of coverage expansion
- Baby boomer pressure on Medicare and Medicaid
- Increasing trends toward cost and quality transparency
- Growing pipeline of high-cost and specialty drugs

1 Consists of Medicare spending minus income from premiums and other offsetting receipts.
2 Includes spending on other mandatory outlays minus income from offsetting receipts.
Source: Congressional Budget Office (February 8, 2017). "The Federal Budget in 2016: An Infographic."

National health expenditure projections

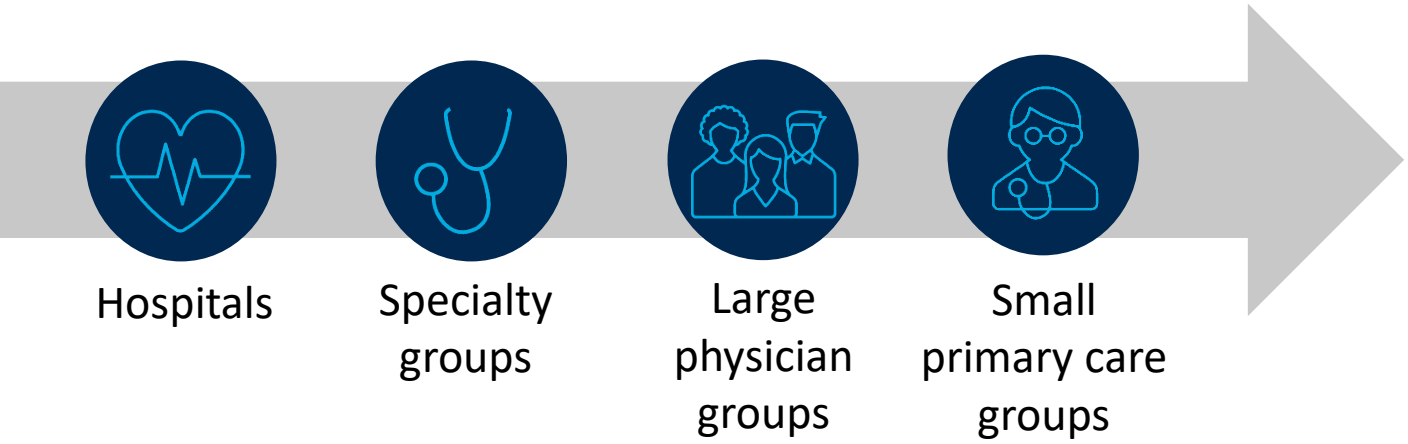
Year over year national health expenditure growth projection by source of funds (2015 – 25)



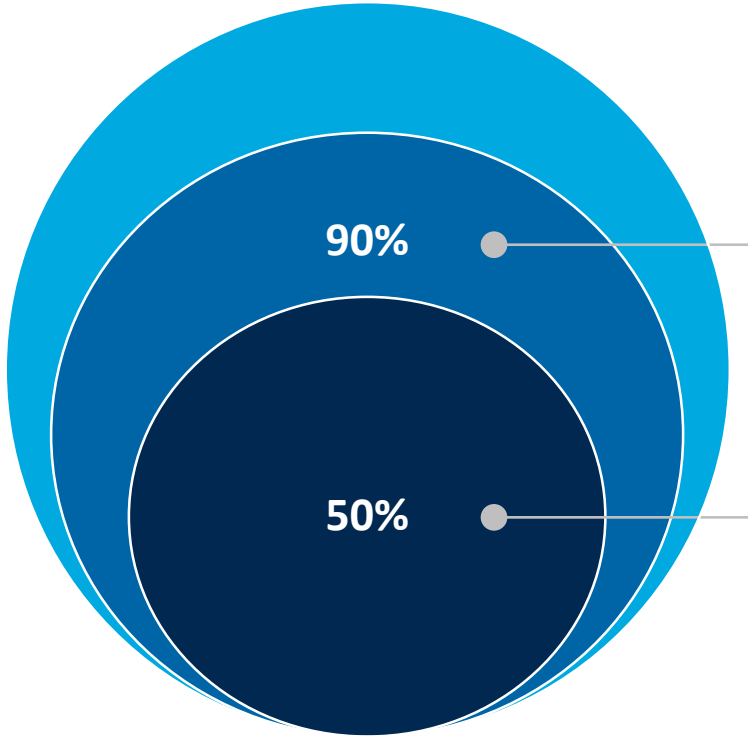
Sources: Sean P. Keehan et al. Health Aff 2015;34:1407-1417. Centers for Medicare & Medicaid Services, Office of the Actuary.

Achieving the 50/90 goal

Value-based contracts across the spectrum



By the end of 2018:



90% of medical payments in value-based arrangements (i.e., FFS payment linked to quality)

50% of medical payments in alternative payment models, including population-based (e.g., capitation, episodes of care)

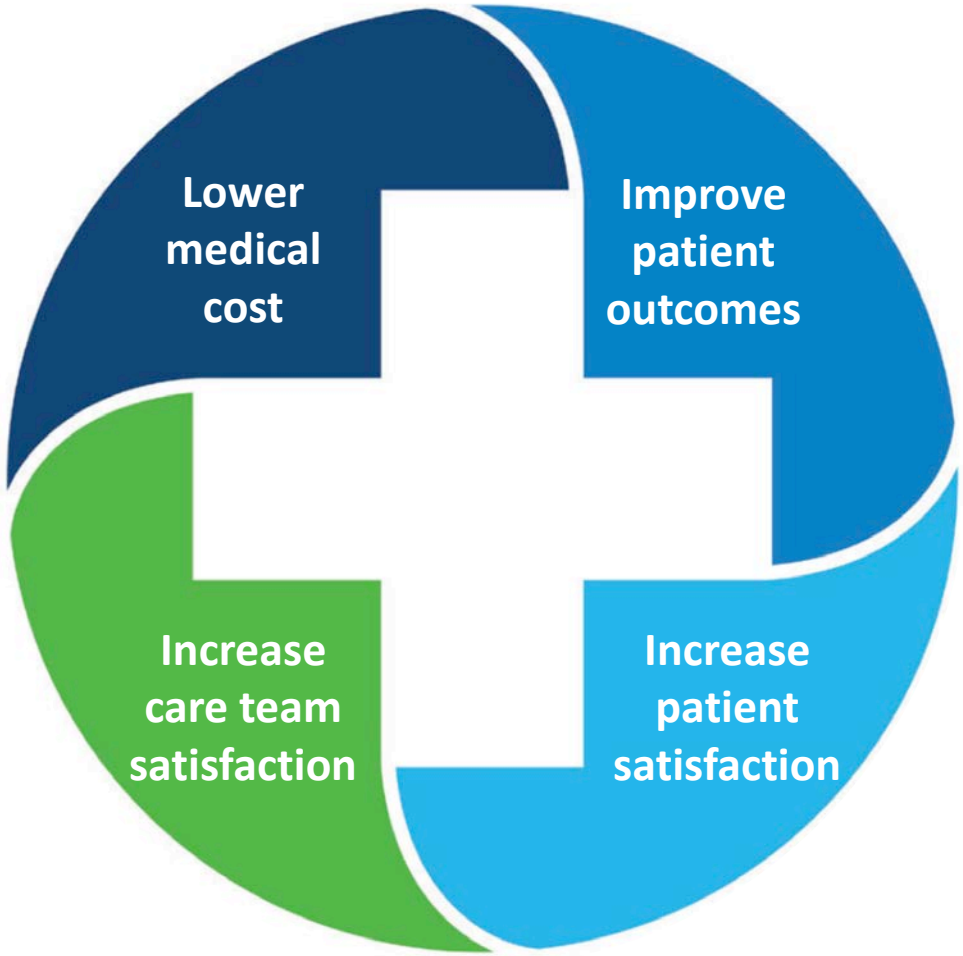
Focusing on fee-for-value

Quality augmentation

Trend reduction

Satisfaction improvement

Quadruple aim

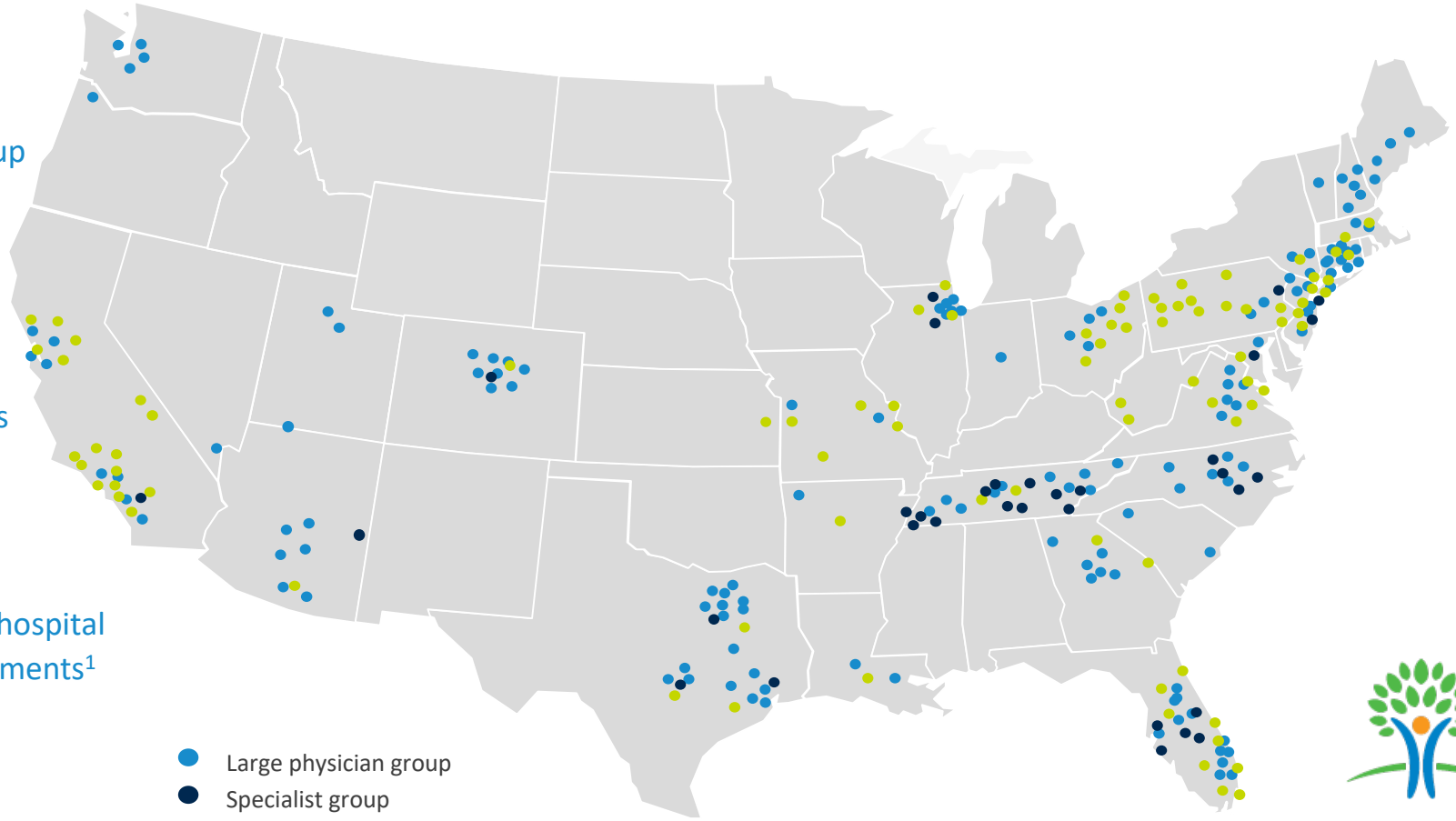


Cigna Collaborative Care arrangements

190+ large physician group relationships[1] – more than any competitor[2]

70+ specialist groups in five disciplines[1]

400+ hospital arrangements[1]



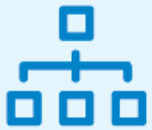
88% of customers are within 15 miles of a participating provider[3]

Cigna®

Map is illustrative.

1. Cigna internal analysis of existing arrangements as of April 2017. Subject to change.
2. Becker's Hospital Review, "A year of mixed results, continued growth for ACOs," November 2014.
3. Cigna 10/1/16 analysis of medical book-of-business (BOB) customers in top 40 U.S. markets, defined by market size, within a 15-mile ZIP code radius (ZIP code to ZIP code distance) of large physician group primary care providers. Subject to change.

Evolving the provider relationship



Traditional network relationship

Any provider in our network not in a value-based payment program (e.g., PPO, HMO, POS).

Enhanced network relationship

Expanded fee-for-service, cost and quality tools, clinical data sharing and flexible network solutions (e.g., LocalPlus® networks, Cigna Care Network).

Value partner

Engaged in a value-based payment contract, including quality bonus and cost targets, embedded care resources for coordination, and data aggregation and exchange (e.g., Cigna Collaborative Care, MSSP).

Delivery system alliance

Network product created around a value-based payment relationship or co-investment through joint venture/other business model.

Solutions for better health. And better business.

PROVIDER ORGANIZATION DEVELOPMENT

Create a physician-led group focused on delivering better financial results while aligning your providers to improve and optimize care of your patients.

VALUE-BASED PROGRAMS

Our expertise in government and commercial accountable care organizations, and MACRA strategy and implementation allows you to focus on ensuring patients get the right care – with quality outcomes.

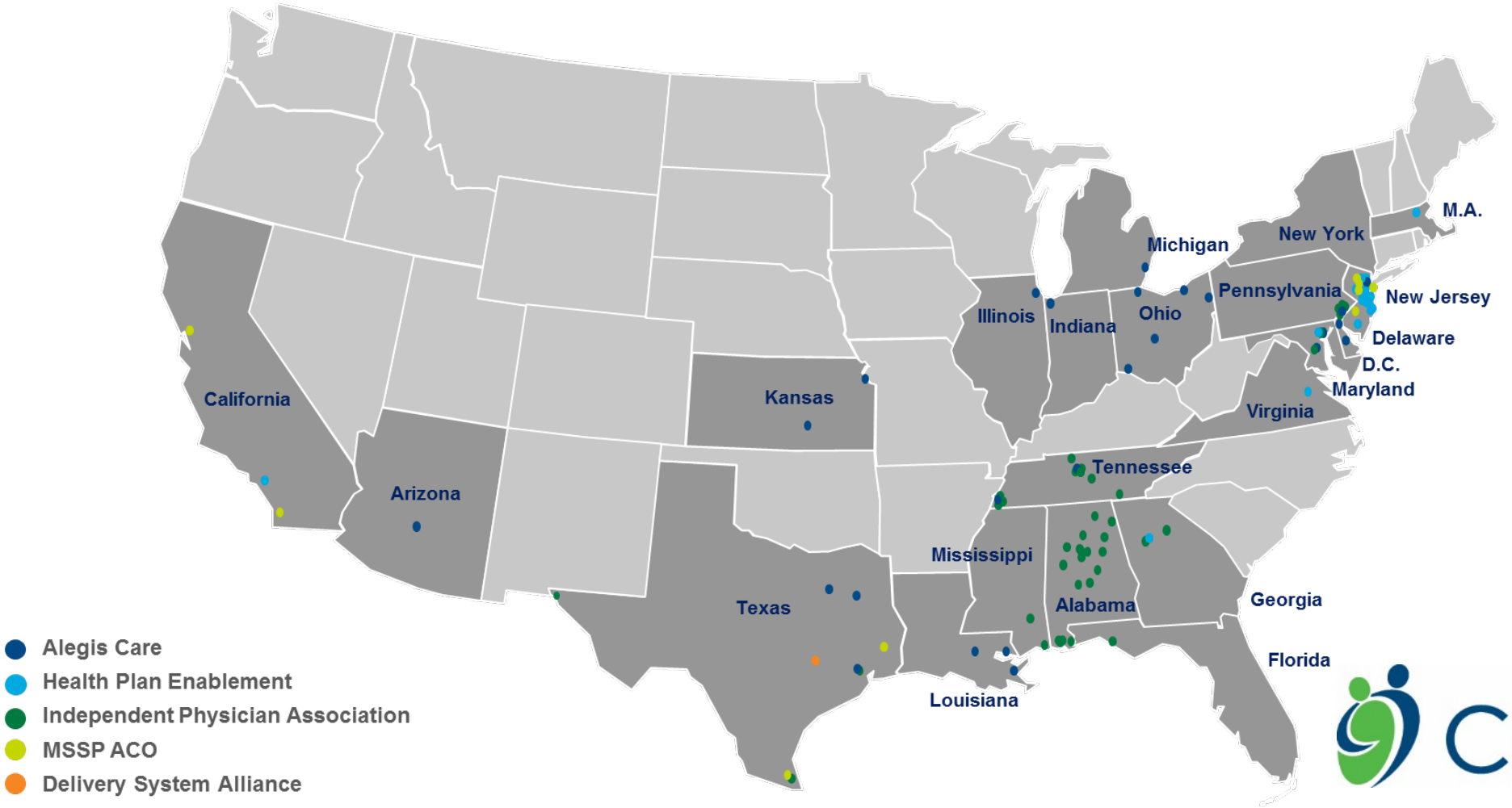
POPULATION HEALTH MANAGEMENT

We can help you align your physicians and move to population health.

MULTI-PAYER HOME-BASED SERVICES

Cost-effective, specialized services delivered in the comfort of the patient's home, including assisted living facilities and independent living facilities.

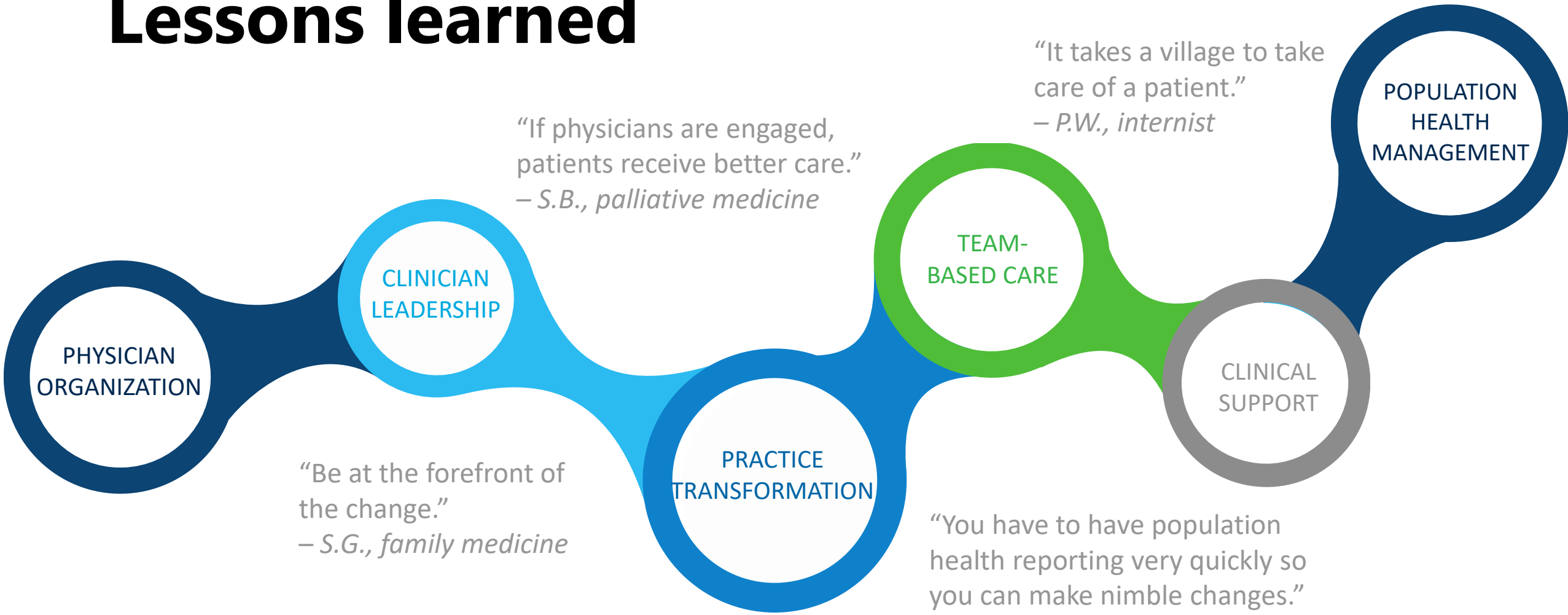
CareAllies customers



CareAllies®

Map is illustrative. Internal analysis of existing arrangements as of July 2017. Subject to change.

Lessons learned



"If physicians are engaged, patients receive better care."
– *S.B., palliative medicine*

"Be at the forefront of the change."
– *S.G., family medicine*

"It takes a village to take care of a patient."
– *P.W., internist*

"You have to have population health reporting very quickly so you can make nimble changes."
– *J.M., urologist*

Providence St. Joseph Health

St. Joseph Heritage Healthcare
Value Based Pay for Performance

Presented by
Christy Mokrohisky

St. Joseph Heritage Healthcare Overview

St. Joseph Heritage manages 8 Medical Group Professional Services Agreements (PSAs) and 6 affiliate networks across California

854 providers; 691 physicians (in foundation models)

1,327 providers in affiliate networks

175 sites

1.3 million square feet of clinic space

1,830 exam rooms

1,800,312 patient visits

3,500 employees

Providence St. Joseph Health

Integrated Healthcare Association (IHA) Pay for Performance (P4P)

One of the largest P4P programs in the country

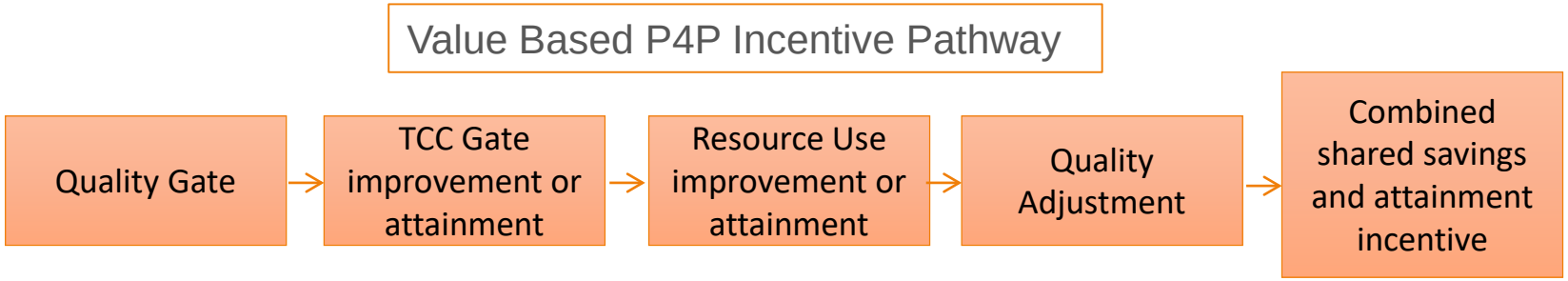
- 16 years running
- 10 health plans participating, 200+ provider organizations representing 40,000 physicians and 9M Californians enrolled in HMO or POS products

Program components:

- Common performance measurement and benchmarking
  - First 10 years focused on quality: 43 commercial and 14 Medicare Stars quality measures and patient experience: CG-CAHPS survey
- Public reporting of results on the CA Office of the Patient Advocate website
- Incentive awards: $500M in awards since the program's start
- Recognition: Top performer and excellence in health care

Value of Care

- In 2014, the program became **Value Based P4P**
- Value is measured through total cost of care (TCC) and high quality. Provider organization must pass gate for both
- Improvement and attainment are rewarded to encourage provider participation
- Upside risk only
- Utilization measures drive cost and are also used to determine incentive payments:
  - **Acute**: Readmission, ED visits/1000, bed days, length of stay and discharges
  - **Outpatient procedures**: % performed in approved facility and frequency of procedures
  - **Pharma**: Specialty pharma and generic prescribing



Providence St. Joseph Health

St. Joseph Case Study

- **IHA Excellence in Healthcare** award to 10% of CA providers for outcomes in TCC, resource use and quality. SJH has won 2 out of 2 years

- **SJH story**: History of strong quality performance and experience in capitation
  - 30% of SJH contracts are capitated (with fixed per-member, per-month payments) for acute and professional services within our integrated delivery network (IDN)
  - 20% additionally are capitated for professional risk only

- **Operating in an IDN**:
  - Costs of services and payment between business segments can be in conflict
  + Can influence how providers and hospitals are paid
  + Operations can establish workflows, set rules and manage unnecessary utilization

- **Commentary**:
  - System leaders support the delegated model and delivery model
  - Understanding this commitment will impact our FFS payment model
  - Most commercial and senior shared savings contracts tie similar quality, cost and utilization measures to incentives

Why Value Based P4P Works

- **Statewide movement**: 40,000 CA providers participate in standardized reporting of quality and cost
- **Financial incentives** allow providers to build infrastructure, resource quality programs and engage individual physicians
- **Standard set of measures** and benchmarks drive improvements in patient care. IHA and Medicare Stars quality measures provide a standard set of measures for other quality programs
- **Decrease reporting burden** for provider organizations by agreeing to one common rating and benchmarking system
- **Providers and payers are involved in program developments**. Choose measures that matter to our payment and delivery models

Suggestions

- Develop a transparent cost measurement system. Although IHA recommends an incentive design, each health plan determines its own methodology for calculating payments
- Cost data needs to be detailed and timely to be actionable
- Health plans entering into shared savings arrangements need to adopt IHA quality measures for their product-specific quality programs
- Adjust timing and size of incentives. As the incentive dollars in VB-P4P decrease, provider organizations may change direction of resources to support other programs with larger incentives

Succeeding with APMs

Structuring Relationships between Payers and Providers

David Kerwar

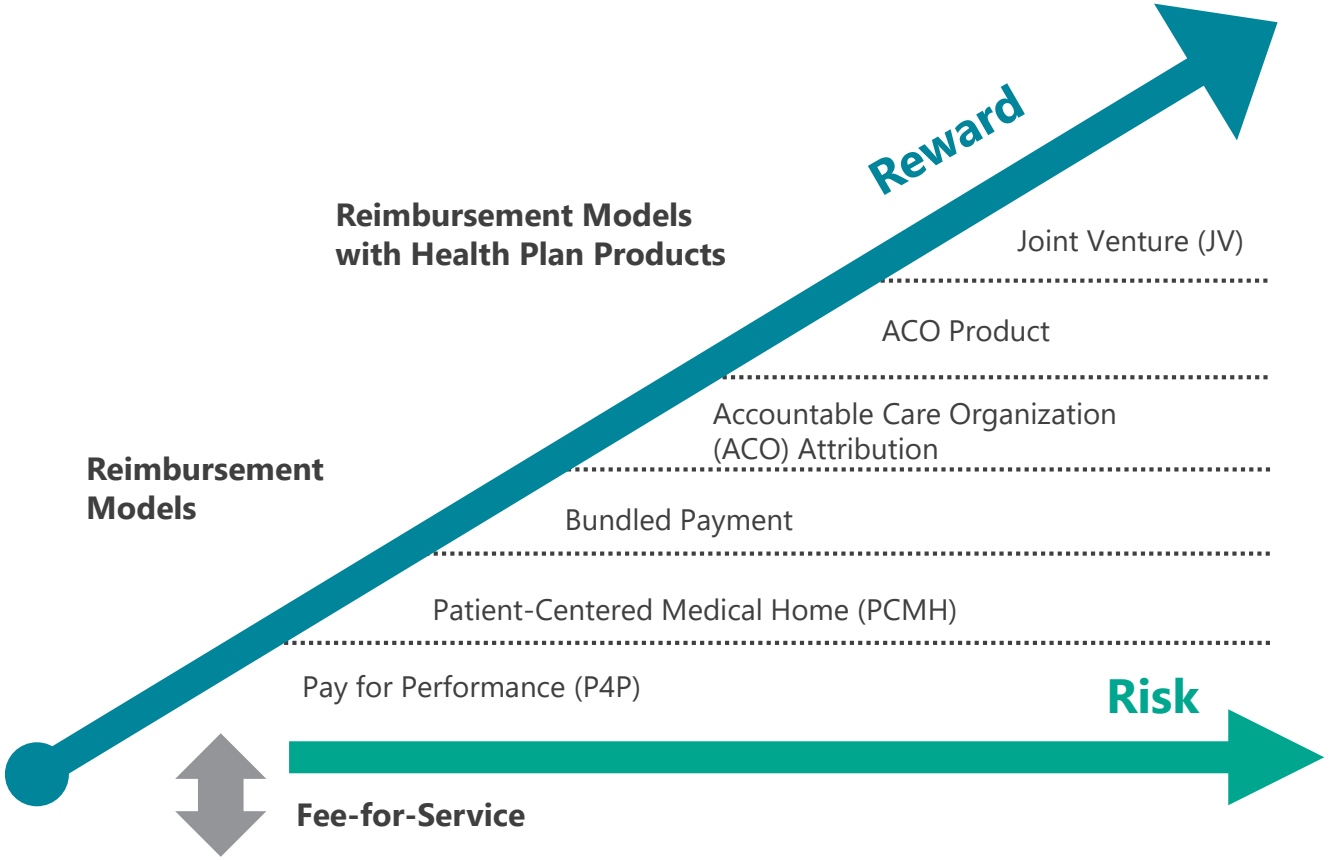
VP, Aetna Joint Venture Business Development

October 2017

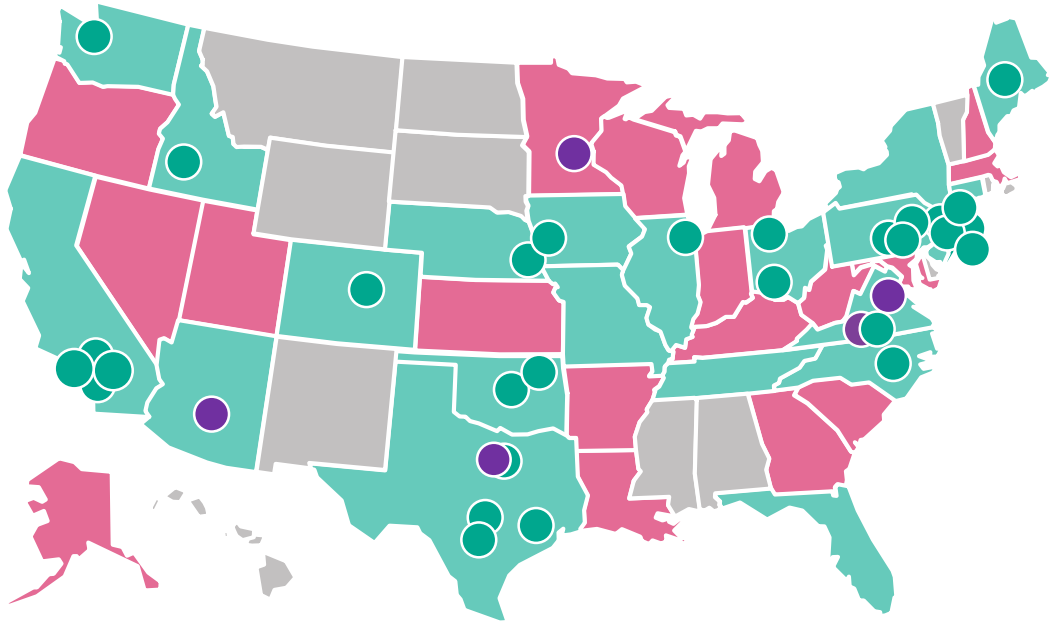
Our portfolio of value-based programs

A multi-year plan to convert our entire network to value – based payment

With a glide path designed to leave no providers out



We already have a solid value-based presence and we're growing quickly



We select providers who can be successful

- States with an ACO product or plan to have by January 1, 2018 (may also have other value-based products)
- States with other Aetna value-based contracts
- ACOs with fully insured product*
- ACOs with both fully insured and self-funded products*
- Joint ventures with fully insured and self-funded products (several pending state DOI licenses)

Above data as of July 2017.

*Deals that meet the industry definition of an ACO: leavittpartners.com/2013/10/really-aco.May represent more than one ACO contract in that location.

1,700+
value-based contracts

48%
of spend in value-based models

aetna

A Joint Venture is Distinctly Different

It fundamentally changes and aligns incentives so that all motivations are driven by one objective – helping members achieve their health ambitions

Provider process

Patient onboarding

Care coordination

Patient services

Revenue cycle

Clinical data

Shared vision *integrates* our *key functions* to drive efficiencies, better outcomes and a seamless member experience.

Insurer process

Member onboarding

Case management

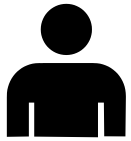
Member services

Claims

Admin data

Multiple JV Models Customized to Provider Objectives

Employers & Unions



Medicare-Eligible Individuals

Health Insurers

Government

JV Health Plan

"Provider-Owned" Health Plan offering best in-class **clinical**, **cost** and **consumer experience**

Ideal for Systems who want:

- the benefits of owning a health plan
- a "direct connection" to purchaser
- to monetize a next gen hc experience

JV Risk Based Entity

Jointly owned Management Service Organization that enables large MD groups to enter into VBCs

Ideal for large practices who want:

- participate in u/w risk w/ multiple payers
- to combine capabilities w/ Aetna and scale
- desire to co-develop pop health capabilities

Thank you!

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A Volume to Value Approach used in an IPA Setting

PCP Bonus Overview

- Designed to compensate physicians for 2 key drivers impacting IPA revenue
  - RAF (Risk Adjustment Factor) or HCC (Hierarchal Conditions Categories) drive Medicare Advantage Revenue
  - VBP4P (Value Based Pay for Performance) historically has been used by health plans to award savings from resource use while achieving quality performance.
- Today P4P is upside risk only, but the healthcare industry is moving toward models that employ upside and downside risk for quality

P4P Overview

- Value Based Pay-for-Performance (VBP4P or P4P) is a quality program, which began in 2001 based on shared savings, adjusted for quality performance. The goal is to move away from traditional utilization payment models and move towards a quality based payment model.
- IHA(Integrated Healthcare Association) established a common set of quality measures that is used nationwide. They partner with the California Office of the Patient Advocate to publicly report Value Based P4P results annually.
- The online quality report card compares physician organization performance within a county, showing overall performance and topic areas, as well as scores on individual measures.
  - Standardized measures also allow consumers to compare the performance of participating physician organizations.
  - Used by health plans to administer their shared savings incentives

PCP Bonus Assumptions Approved by the BOD

- PCPs must be active as of the date of the bonus distribution
- Do not pay bonuses less than $100

P4P Bonus Criteria- Qualifying

- All PCPs are eligible
- Measures are included based on all PCP performance. If a large number of PCPs performed poorly, then the measure will not be included in the bonus.
  - Benchmark: Measure included if ≥30% of PCPs achieved the 70th percentile.
  - 34 measures were included. 15 measures were excluded.
- There are 2 quality gates that must be achieved to qualify for a P4P bonus.
  - **Quality Gate 1** → Must have a ***total completion score*** of at least 60% across all measures.
  - **Quality Gate 2** → Must reach the ***60th percentile*** according to IHA CA benchmarks

P4P Bonus Calculation

- All qualifying PCPs (passed Quality Gate 1 & 2) are initially treated the same and receive a percentage of the bonus based on the ratio of completed patients.

$$\frac{\textit{(PCP \# of completed members)}}{\textit{(All PCP \# of completed members)}} \times \textit{(Available Bonus amount)}$$

- Bonus deductions are made based on exclusivity and percentile rank.

Exclusivity Status	Deduction
Exclusive	0%
Non-exclusive	30%

Percentile Rank	Deduction
≥ 90th	0%
$80^{th} – 89.9^{th}$	10%
$70^{th} – 79.9^{th}$	20%

- All deductions are redistributed back to exclusive PCPs

HCC Overview

- Hierarchal Conditions Categories (HCC)or RAF (Risk Adjustment Factor) is used CMS to reimburse health plans and physician organizations based on the health status of the population being managed.

- Two components of total MA revenue:
  - Demographic Score: Age and Gender of each member
  - RAF/HCC: scores assigned based on documenting member health status

- Capturing an accurate portrayal of each member's health status is essential to ensuring that sufficient funds are available to manage each unique member's health

HCC Bonus Criteria - Qualifying

- All PCPs with MA members are eligible
- There are 2 quality gates that must be achieved to qualify for a HCC bonus.
  - **Quality Gate 1** → MWOV = 7%
    - Health plan target is <5%. SCCIPA average is 5% but the higher rate was used to allow for smaller population variances
  - **Quality Gate 2** → Must achieve **>65.8%** recapture rate,
    - Health plan target is 80% for 5 Star ratings. SCCIPA average is 65.8%.

HCC Bonus Calculation

- All qualifying PCPs (passed Quality Gate 1 & 2) are initially treated the same and receive a percentage of the bonus based on the ratio of Total RAF to All PCP Total RAF.

  $$\frac{\textit{(PCP Total RAF)}}{\textit{(All PCP TOTAL RAF)}} \times \textit{(Available Bonus amount)}$$

- Bonus deductions are made based on exclusivity , Annual Wellness Visit (AWV) completion, MWOV and recapture rate. All deductions are redistributed to exclusive PCPs

Exclusivity Status	Deduction
Exclusive	0%
Non-exclusive	30%

AWV completion	Deduction
80 – 100%	0%
60 – 79.9%	5%
40 – 59.9%	10%
20 – 39.9%	15%
0.1 – 19.9%	20%
0%	25%

MWOV	Deduction
0 – 0.9%	0%
1 – 1.9%	5%
2 – 2.9%	10%
3 – 3.9%	15%
4 – 4.9%	20%

Recapture rate	Deduction
90 – 100%	0%
80 – 89.9%	5%
70 – 79.9%	10%
60 – 69.9%	15%

PCP Bonus Physician Stats

	2016	2015	2014
ALL PCPs (at the time of the bonus)	**226**	**230**	**264**
Excluded due to employment model status	**37**	**20**	**50**
Exclusive PCPs	**95**	**86**	**91**
ALL PCP receiving bonus	**89**	**102**	**71**
% of total PCPs net of excluded	49%	50%	35%
Family Practice	29	34	27
Internal Medicine	46	48	29
Pediatricians	14	20	15
Exclusive PCPs receiving bonus	41	50	35
% of Exclusive PCPs	43%	58%	38.5%