Implementing an EOC Colonoscopy Contract in GI

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Disclosures

- None

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Who We Are… and Growing

- Seven-member GI group
- Two room ASC
- Employ anesthesiologists
- Employ pathologists
- In house pathology lab
- In house infusion center
- Virtual colonoscopy

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Bringing Value

- Community-based gastroenterologist for 30 years
- Full time gastroenterology. Changes will affect me personally
- Early adopter of change to Value Based Contracts
- Can speak to the changes Value Based Contracts induce in the every day practice of medicine

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Colonoscopy Episode of Care

- Designed first contract with Horizon Blue Cross Blue Shield of New Jersey
- Based on PROMETHEUS payment model and work done at Healthcare Incentive Improvement Institute, (HCI3)
- Expanded to many other practices in NJ

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Retrospective Contract

- Least amount of infrastructure change to practice
- No downside financial risk
- FFS with upside-only shared savings

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Quality Measures

- Based on GI Societies recommendations
  - Adenoma detection rate
  - Cecal intubation rate
- Included **Patient Satisfaction** as a quality measure.
- Shared savings obtained only if quality measures reached.

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Implementation Lessons Learned

- These new models require substantial cultural, operational and infrastructure changes that need to be supported financially
- Shared Savings may not be enough to support above.

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Physician Leadership

- Identify lead physician to implement and monitor contract
- Financially support lead physician as the "Episode Conductor"
- Responsible for motivating, teaching, monitoring and disciplining fellow physicians
- Respected and works as a clinician, so as to be able to change clinical behavior

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Staff

- Needs to be educated on these new types of contracts
- Staff-patient interaction needs to be at highest level as patient satisfaction is a quality measure
- Maximize patient access to practice to minimize use of ER and higher cost facilities

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Quarterly Review

- Lead Physician “ Episode Conductor”
- Billing Manager
- Payer representative

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Quarterly Review

- All patient's costs reviewed
- Clinical notes and procedure reports compared to costs
- Opportunities for clinical and financial improvement identified and communicated to other physicians and staff
- Protocols based on results established

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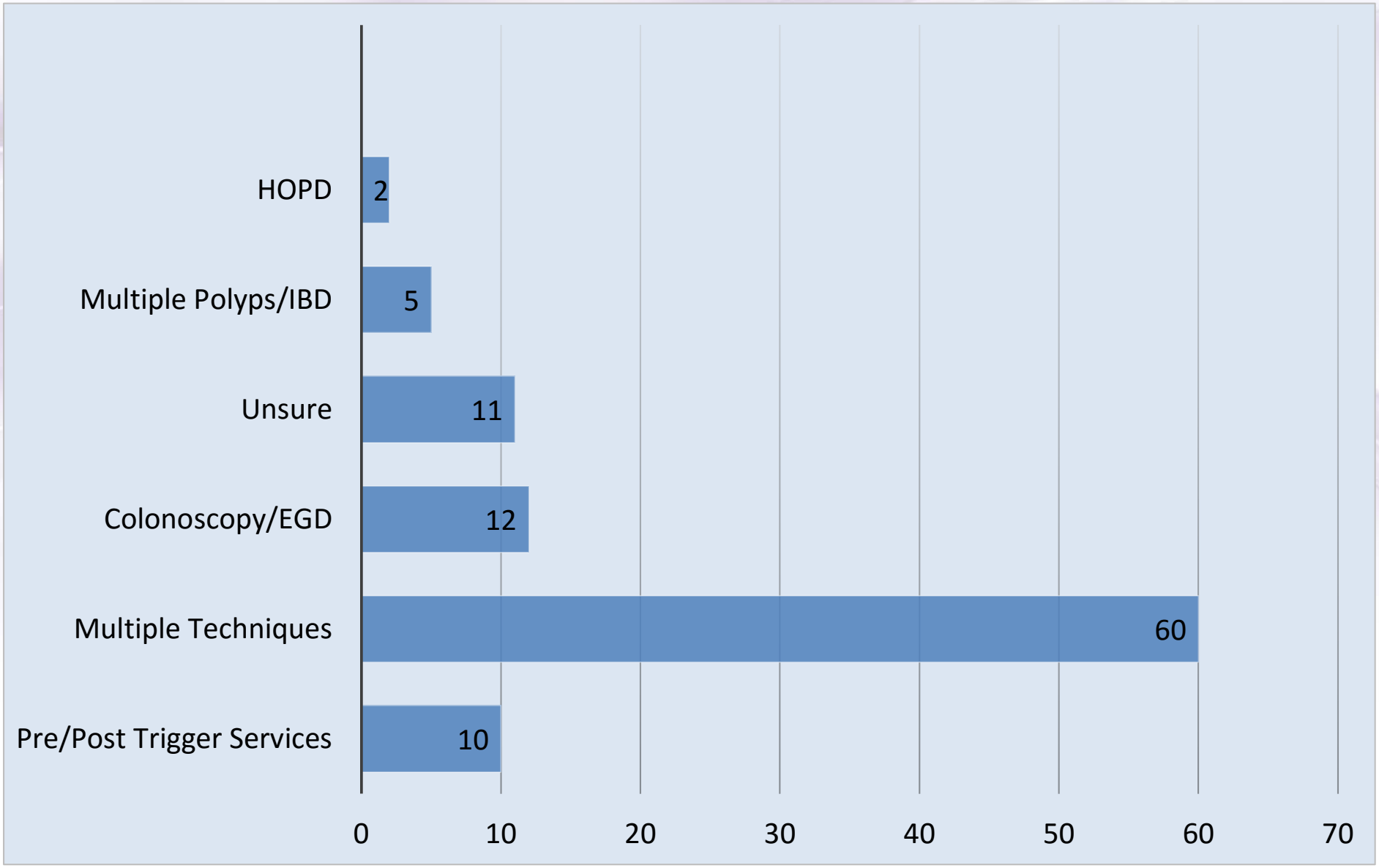
3rd and 4th Quarter Over Budget



Achieving Savings

- Provide service in a lower cost ASC as opposed to HOPD
- Standardize care across providers.
  - Appropriate indications
  - Appropriate follow up intervals
  - When to biopsy
  - Standardized preop preparation
  - Monitor rate of incomplete colonoscopies --- why?

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Achieving Savings

- Attention and management of costs in the Pre and Post Trigger period
  - E.R. visits
  - Complications
  - Lab
  - Radiology
  - Many costs not under our control

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Achieving Savings

- Maximize patient access to practice
  - Same day appointment
  - Open emergency slots
- Coordinate care with referring providers
  - Clinical and financial alignment
  - Particularly in risk bearing PCMH,ACOs
- Educate patients to seek out these programs that offer quality standards and cost less.

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Results (2.5 years)

- 97% patient satisfaction rate (Horizon Data)
- Episode partners trending better in terms of quality and cost (Horizon Data)
- Shared Savings obtained but not enough to cover infrastructure changes for most practices(pc)
- Additional payments/resources needed to better manage patient care
- Colonoscopy is a high volume low acuity procedure
  - No drastic cost savings if already being done in ASC

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Results

- Have cultivated new working relationship with payer
- Learning to manage full packages of services for GI
- We are getting better at communicating, collaborating and coordinating care
- Starting to understand how to create success in value-based contracts

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Developing Opportunities

- Colonoscopy Prospective Bundled Contract with Strong Regional TPA
- Project Sonar. The chronic care of the IBD patient.

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Gastrointestinal Disease

- NIH estimates 60 to 70 million people affected with GI disorders (1)
- 141.8 Billion per year (1)
- Aging population will increase disease burden
- Crohn's Disease and Ulcerative Colitis (IBD) are two chronic diseases accounting for substantial amount of costs.

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Gastrointestinal Disease

- 54% of GI costs nationally related to CRC screening (2)
- In 2010 CRC cost Medicare $14.14 billion(3)
- In 2010 Medicare covered 3.3 million colonoscopies (4)
- Nationally costs over 10 billion per year for 10 million colonoscopies (5)

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Gastrointestinal Disease

- IBD affects 1.4 million people in U.S. (6)
- IBD responsible for 25% of costs in gastroenterology (7)
- A patient with Crohn's disease spends $13,500 to $17500 more per yr than typical patient without Crohns disease.(8)
- 40% of expenses for IBD are for hospital services (7)

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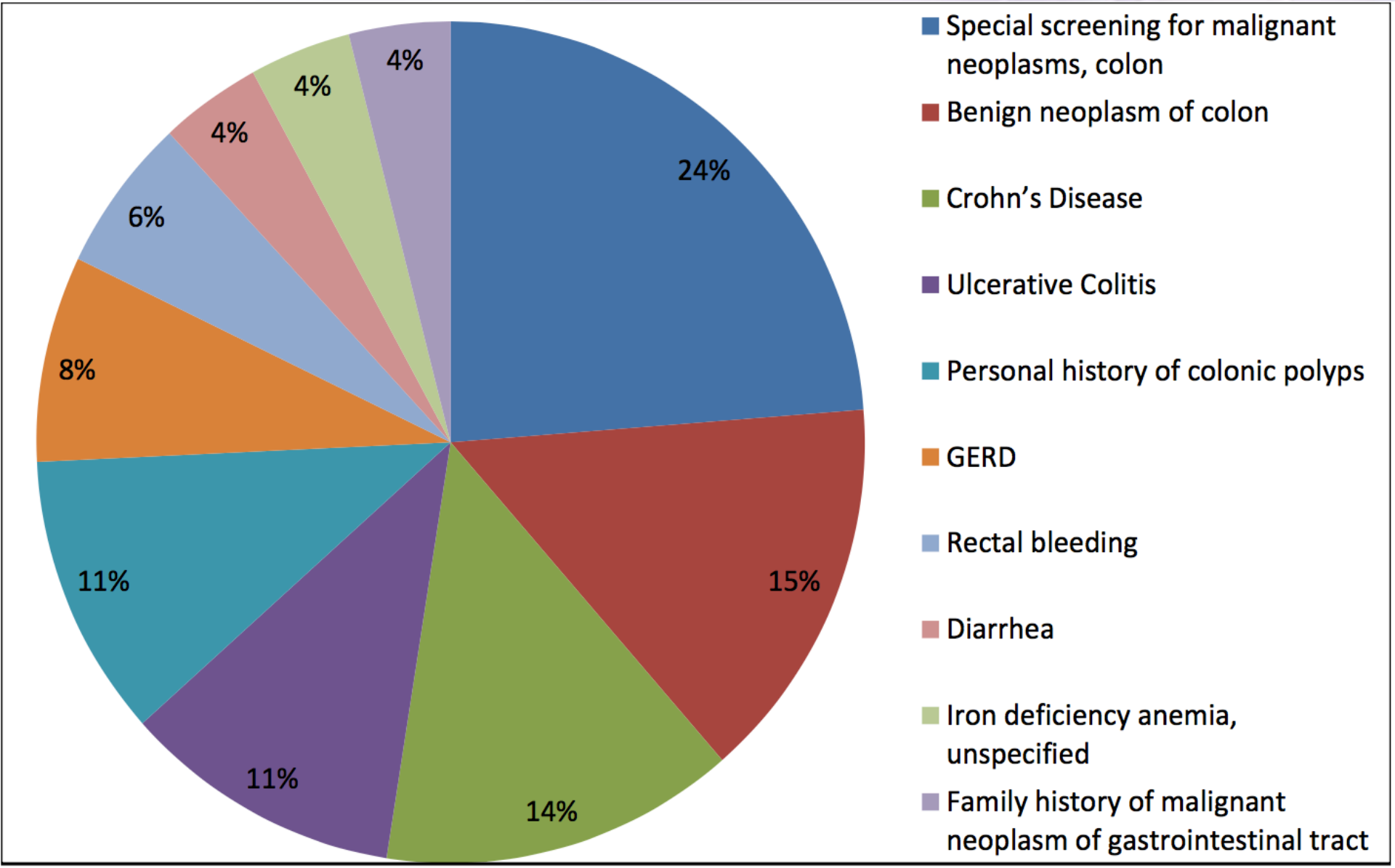

Figure 1: Top Ten Gastroenterology Cost Drivers by Procedure. *Source:* Kosinski, L. R. (2014). Building Your Nonprocedural Business Lines. AGA Roadmap to the Future of GI Practice.

Prospective Bundled Contract

- Opportunity to develop a fixed price for colonoscopy services.(9)
  - Tied to measuring and reporting quality
  - Tied to patient Satisfaction
  - Redo if inadequate prep
  - Appropriate interval repeat colonoscopy
- Downside risk for potentially avoidable complication (in negotiations)
- Gastroenterology group is the convener

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Implementation hurdles

- Works best IF physician group controls all the downstream costs
- IT infrastructure at both payer and provider level
- EHR's interoperability a barrier to development.
- Need relief from current anti-kickback laws

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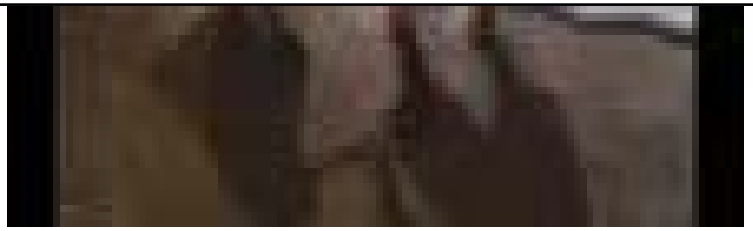
Project Sonar



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Project Sonar

- Many Crohn's patients do not participate in regular disease management
- May seek care once disease is advanced requiring more advanced treatment and or hospitalization
- Better communication between patients and providers could limit progression of disease

Project Sonar

- Patient portal used to reach out to patients to monitor care needs for earlier intervention
- Clinical decision support tools encourage adherence to evidence based guidelines
- Standardizes care across multiple providers

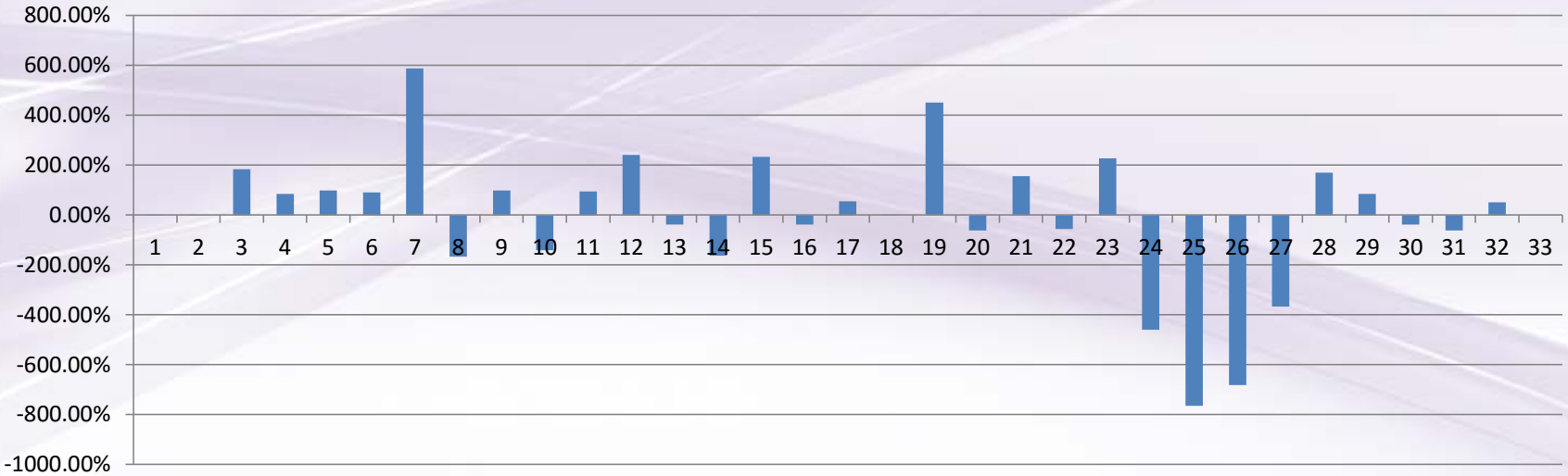
BCBS Data Financial Summary

- 21,000 Patient database
- Two years of experience
  - $240M in annual expenses for Crohn's disease
  - $11,000 per patient per year
- > 50% of all expenses paid are for hospital services
  - Likely to be primarily complication related
  - This is the fastest growth area of expense
- Biologics are 10% of total expenditure

BCBS Data Financial Summary

- Gastroenterologists receive 10% of all professional payments and only 3.5% of total payments
  - But we manage the illness and complications!
  - Is there an opportunity to improve care at the provider level?
  - A potential for a shared savings program exists

Hospital Admissions



- Overall Hospitalization rate was 17%
- Hospitalization Rate for patients on a biologic was 12%
- Hospitalization Rate for patients receiving office infusions of biologics < 5%
- <u>Less than 1/3 of the patients admitted were seen by a physician in the 30 days prior to admission</u>

Project Sonar Intensive Medical Home Business Model

- Supplemental PMPM Payment AND Initial upfront patient enrollment fee.
  - Establish Clinical Infrastructure
    - NCMs in each office location
    - Medical Directors in each office location
  - Support Development of IT Platform
    - CDS Tools
    - Patient Engagement Platform

Project Sonar Intensive Medical Home Business Model

- Shared Savings
  - Based upon decrease in cost after an evaluation period as compared to an unmanaged group – 10:1 ratio of patients
  - Shared Savings to readjust PMPM going forward
  - Per Patient Cost Capped
  - No downside risk

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BCBS Intensive Medical Home Program Details

Attribution Period

- The payer attributes your patients to you
- They will be your existing patients that are under this payer for at least 12 months
- They cannot be in another Shared Savings Program, i.e.: ACO

Enrollment Period

- A Supervisit must be performed on each attributed patient during this period
  - This is a nurse visit coded with an "S-code" and billable
  - You can combine a provider E&M Visit at the same time
- Perform a risk assessment using the SonarMD Platform
- Establish a treatment plan based on the risk assessment using the AGA Crohn's Disease Care Pathway

Performance Period

- Shared savings based upon your performance as measured against a control group
- Each patient must be "touched" on a monthly basis – Sonar Pings qualify
  - Hospitalizations must be closely monitored
  - ER Visits must be tracked
- You will receive full claims data quarterly to monitor your progress

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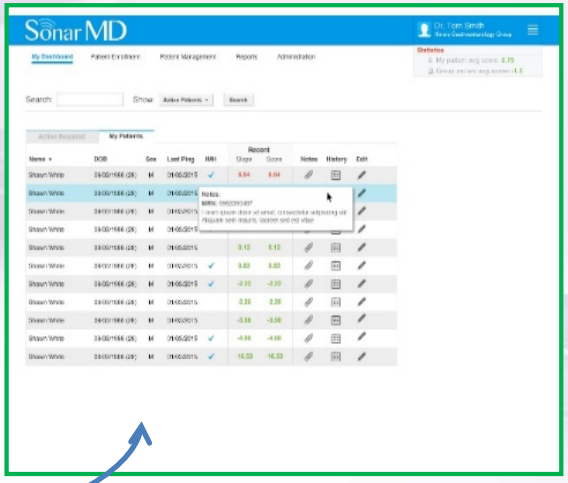
Web-based Patient Engagement Tools

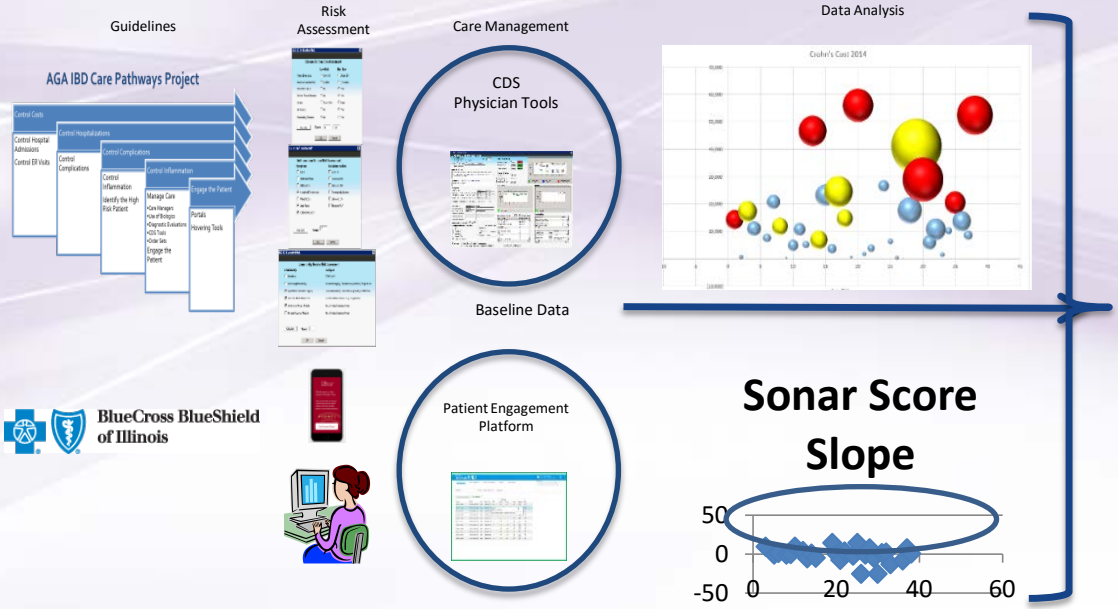


CDAI = Sum((2S)+(5P)+(7G)+(20Sum(c) +(30D)

Algorithm for automated responses drives behavior

What patients tell you (subjective) is different from what really happens (objective) reporting

Putting It All Together



Predictive Analytics

CDCP Risk Factor	Odds Ratio	95% Confidence Limits	
Inflammation risk: albumin	19.4	3.9	97.8
Inflammation risk: joint pain	5.7	2.2	14.5
Comorbidity risk: inflammation	11.5	1.5	87.8
Comorbidity risk: stricturing	5.4	2.2	13.4

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Conclusions

Project Sonar is a successful example of population health

- Hospitalization rate cut by more than 50%
- Cost of care decreased more than 20% based upon lower utilization
- Improved patient satisfaction
- Generated more revenue for our practice

Why were we successful?

- Providers practicing according to guidelines
  - Using CDS Tools
  - Team-based care model
  - Appropriate use of risk assessments
- We engage the patients
  - Every patient is proactively “touched” once a month
  - We intervene before they even realize that they are in need of care

Conclusions

- Involving GI specialists in specialty specific chronic disease management leads to better quality and decreased costs.
- Some diseases best managed primarily by GI in conjunction with PCP
  - IBD
  - Chronic/end stage liver disease
  - Colorectal cancer Screening
  - ?others

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Conclusions

- Upfront payment reform leads to better care at a lower cost
- Payers are PAYING A LOT for complications and hospitalizations
- Payers could be SAVING A LOT by supporting specialty practices in specialty specific chronic disease management programs

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Conclusions

- Independent of ACO/PCMH movement
- Physicians receive a minority of healthcare payments
  - GI 3.5%
  - Ortho 4%
- ?Opportunity to attract physicians and other providers to value based contracts and change their behavior by readjusting the clinical and financial incentives.

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Value-Based Care

- Changes the relationship between **Patients**, providers and payers
- It's good for **Patients**
- Places **Patients** back in the center where they belong!

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Thank you

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