New York Presbyterian
Innovations in Health Care Reform at
Academic Medical Centers

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Should Tertiary Referral Centers do Population Management?

- **Con**
  - Primary care is a small percentage of AMC NPSR
  - Population management requires significant resources-management and IS intensive
  - An AMCs reputation not based on primary care
  - Marginal contribution to cost savings

- **Pro**
  - AMC commitment to defining the future of medicine
    - Delivery innovation just as important as biologics
  - Focus on total costs of care is important discipline
  - Learning to better manage tertiary services for internal referral sources helps with external referral sources
  - Demonstrates AMC commitment to being part of the solution
  - 4th Mission of AMCs – serving the local community
  - Disproportionate impact on reputation
Partners Overview

- Total Partners Acute Hospital Revenue
  - EMASS 82%
  - Other Mass & Out-of-state 18%
  - MGPO & BWPO 19%
  - PCHI (includes CH PCPs) 18%
  - Non-PCHI & Self-Referral 44%

- 62% of Partners patient revenue comes from non-PCHI patients
- We need to manage costs of our referral business and our population – may take different methods
- Much more referral/specialty revenue is in outpatient than in the past
Management’s Tasks for implementing

- Develop and deploy the internal systems that improve quality & decrease costs
  - New IS functionality
  - New people/skill mix
  - New processes (management and practice based)

- Need to be bound by payer contracts that support these internal goals: 3 options
  - Improved FFS rates and use margin to build infrastructure
    - Requires control over funds flow
  - FFS with pmpm to build infrastructure (e.g., medical home)
    - Lowest risk option
  - Capitation
    - ACO, Pioneer ACO, AQC
## High Risk Sub-Populations by Payer

<table>
<thead>
<tr>
<th>Population</th>
<th>Medicare ($10k)</th>
<th>Medicaid ($6k)</th>
<th>Commercial ($2K)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frail / Elderly</td>
<td>+++</td>
<td>++</td>
<td>N/A</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>+</td>
<td>+++</td>
<td>+</td>
</tr>
<tr>
<td>Disabled (MH)</td>
<td>++</td>
<td>+++</td>
<td>N/A</td>
</tr>
<tr>
<td>Disabled (Other)</td>
<td>+++</td>
<td>+++</td>
<td>N/A</td>
</tr>
<tr>
<td>Multi-chronic illness</td>
<td>+++</td>
<td>++</td>
<td>+</td>
</tr>
<tr>
<td>Single prevalent major condition</td>
<td>++</td>
<td>++</td>
<td>+++</td>
</tr>
</tbody>
</table>
## Engaged Provider Tactics

<table>
<thead>
<tr>
<th>Access to care</th>
<th>Longitudinal Care</th>
<th>Episodic Care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Primary Care</td>
<td>Specialty Care</td>
</tr>
<tr>
<td>Patient portal / physician portal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extended hours / same day appointments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expanded virtual visit options</td>
<td>Defined process standards in priority conditions (multidisciplinary teams, registries)</td>
<td></td>
</tr>
<tr>
<td>Design of care</td>
<td>High risk care management</td>
<td>Required patient decision aids</td>
</tr>
<tr>
<td>Provide 100% preventive services</td>
<td>Appropriateness</td>
<td>Hospital Acquired Conditions</td>
</tr>
<tr>
<td>EHR with decision support and order entry</td>
<td></td>
<td>Hand-off standards</td>
</tr>
<tr>
<td>Incentive programs (recognition, financial)</td>
<td></td>
<td>Continuity Improvements</td>
</tr>
<tr>
<td>Internal variance reporting / performance dashboards</td>
<td>Publicly reporting of quality metrics: clinical outcomes, satisfaction</td>
<td></td>
</tr>
<tr>
<td>Costs / population</td>
<td>Costs / episode</td>
<td></td>
</tr>
</tbody>
</table>
Chronic Conditions – MGH Medicare Demo

**MGH Demo**

- Medicare selected MGH to participate in a 3-year demonstration project focusing on high-cost beneficiaries in 2006
- Success validated in 2010 (RTI evaluation)
- Contract renewed through 2012
- Expanded to Brigham and Women’s and North Shore Medical Center

**Enrolled 2,500 highest cost Medicare patients with total annual costs of $68 M**
- Average number of medications = 12.6
- Average annual hospitalizations = 3.4
- Average annual costs = $24,000

**Payment model similar to proposed shared savings for ACOs**
- Paid monthly fee based on number of enrolled patients
- Required to cover costs of program +5%
- Gainsharing if savings greater than cost +5%
- Success determined using prospective matched comparison group

 Opportunity

10% of Medicare patients account for nearly 70% of spending

http://www.massgeneral.org/about/newsarticle.aspx?id=2531
Chronic Conditions – MGH Medicare Demo

Results from Independent Evaluator (RTI)

- 12 care managers embedded in primary care practices
  - Coordinate care; point person for acute issues
  - Identify patients at risk for poor outcomes
  - Facilitate communication when many caregivers involved

- Key characteristics
  - Care managers have personal relationships with patients
  - Care managers work closely with physicians
  - All activities supported by health IT (universal EHR, patient tracking, home monitoring)

- Successful Outcomes
  - Hospitalization rate among enrolled patients was 20% lower than comparison*
    - ED visit rates were 25% lower for enrolled patients*
  - Annual mortality 16% among enrolled and 20% among comparison

- Successful Savings
  - 7.1% annual net savings (12.1% gross) for enrolled patients
  - For every $1 spent, the program saved at least $2.65

*Based on difference in differences analysis
Program Improvements to Meet Subpopulations Needs

- Embedded Primary Care as hub
  - Care manager for high risk
  - Population manager for metrics, disease specific programs

- Centralized Services
  - Community Health Worker
  - Psychiatry / Social Worker
  - Pharmacy

- Predictive modeling
  - Sub-populations (disease specific programs e.g., CHF)
  - Readmissions

- Mass customization
  - Individual assessments (what is the mix of problems?)

- Incentives, notification, performance reports
Identifying Opportunity

- **Predictive Models**: Ideal and Real
- Medical Claims Data
- Pharmacy Claims Data
- Demographics
- Patient Reported Information (Health Risk Assessment)*
- Medical records*
- Laboratory Data*

Most programs model “risk” and not “opportunity”
Why Have Care Management Results Been So Modest?

- **Flaws in Concept**
  - Expected big results rapidly (programs require maturation, CQI)
  - Intervention differed little from usual care
  - Participants not the ones with high costs (selection)
  - Limits to patients’ “self management” of complex illness (esp. psych)

- **Flaws in Design**
  - Interventions were not sufficiently standardized or robust
    - Targeting of appropriate patients
    - Low prevalence of some outcomes
  - Programs more effective if patient choices are constrained
  - Neuro-psych issues not sufficiently accounted for

- **Flaws in Implementation**
  - Internal approval processes took too long
  - Challenges in recruiting patients quickly

Gold M et al, Health Affairs. 2005;W5-199
Drops in Potential for Care Management

Potential Opportunity

Identification

Reach/engage

Find opportunities for improvement

Intervention

Realized Improvement

Adapted from J Eisenberg JAMA. 2000
Summary to Date

Analysis of fit of **ACO proposed rule** with PHS strategy
- Dec 2010: Financial analysis memo submitted to White House
- May 2011: Proposed Rule announced
- June 2011: Submitted comments on proposed rule
- Key Issues identified
  - Retrospective assignment of Medicare beneficiaries
  - Payments for teaching hospitals and safety net hospitals included in the financial calculations
  - Inclusion of quality measures in shared savings
  - Adjustments for policy payments and case mix

Analysis of fit of **Pioneer ACO** with PHS strategy
- RFI issued May 17, 2011
- PHS Letter of Intent (LOI) submitted June 21, 2011
- Application in process – Due August 18th
- Key issues are being processed in ACO Planning and ACO Advisory Committee and Operating Heads
Pioneer ACO

**Definition**
- Vanguard organization interested in the transformation of their business and care delivery model from one reliant on fee for services to one focused on optimizing outcomes of care for populations

**Key Characteristics**
- CMS intends to enter into agreements with ~30 organizations
- Pioneer ACOs will inform the design of the SSP in the future
  - Timeframe: 3 years (plus 2 additional, if desired)
  - Minimum of 15,000 beneficiaries
  - Prospective assignment of aligned patients
  - 2 sided risk with transition to population based payment in year 3
  - Minimum Sharing Rate (MSR): flat 1% below national trend with first dollar savings
  - 35 performance metrics – scores influence shared savings
### Pioneer ACO Application: Key Issues

#### Organizational
- Who should be included in the ACO?
  - Owned Hospitals
  - PHOs
  - Affiliates
- Can we pull this off?

#### Financial
- Any efficiencies created by CMS Demo will be in our baseline
- Will model work for us?
  - AWI issue
  - 50/50 trend issue
- Total size of our risk?

#### Governance
- What is the ACO Governance Structure?
- How will risk be apportioned?

#### Legal & Market Context
- What is the relationship between the entities within the ACO?
- How does our participation in Pioneer ACO affect our local market?