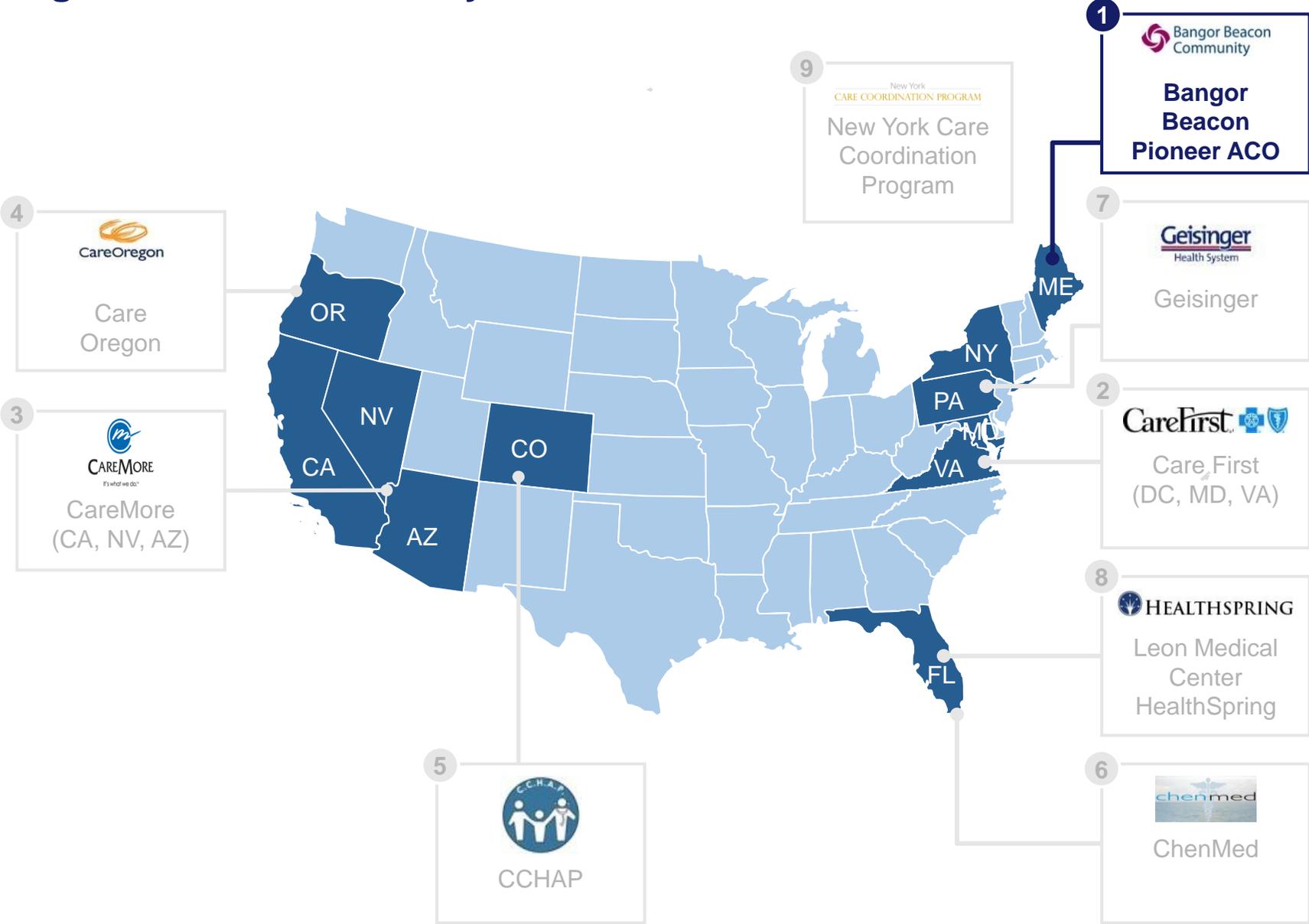


A decorative graphic on the left side of the slide, consisting of a grid of overlapping diamond shapes in various shades of blue, creating a textured, geometric pattern.

Care delivery model case examples

Reference document
June 10, 2013

Bangor Beacon Community Pioneer ACO



Why was a change in care delivery considered?

- **Eastern Maine Healthcare Systems (EMHS)** led applications for both ONC grant and CMS Pioneer ACO designation
- **Bangor Beacon Community (BBC) program** aimed to promote cost-effective care through care coordination and patient self-management by leveraging existing and establishing new health information technology infrastructure
- **Beacon LLC Pioneer ACO** builds on the BBC care delivery model by incentivizing financial sustainability

What was the scope of the care model?

- **BBC program** targets patients with chronic conditions, with clinical transformations affecting greater Bangor region
- **Beacon LLC ACO** covers ~22K Medicare beneficiaries
- **Quality outcomes and cost savings** were used to measure program success

What were the changes made?

- **Nurse care managers** were added to each primary care practice to design care plans and coordinate care on behalf of patients
- **High level of healthcare technology** enabled model

How was the care model put in place?

- **EMHS** was the lead organization behind both the BBC program and Beacon LLC
- **ONC grant** was received in May 2010
- Necessary health IT and clinical interventions were operation by **September 2010**
- Beacon LLC was designed a Pioneer ACO in **October 2011**

How did payment reform support care model?

- **All 9 participating hospitals** are responsible for delivering savings to the Medical program
- **Pioneer ACOs** operate over 3-year period
 - Y1: upside-only
 - Y2: increased upside- and down-side risk
 - Y3: capitation and shared revenue from risk sharing contract

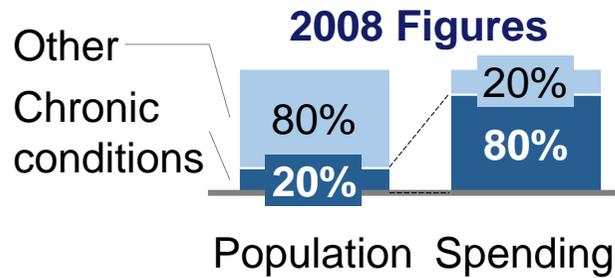
What was the impact in terms of quality and costs?

- **Improved outcomes** in diabetes (45% decrease % patient with HbA1C >9) and chronic health failure patients (9% increase in % patients with BP <130/80)
- **Reduced healthcare utilization:** both ED visits and hospital admissions decreased ~40% 12 months after intervention
- Beacon LLC achieved **3% cost savings** in its first three quarters as a Pioneer ACO, outperforming 25/32 peer providers

1 Why was a new care delivery model considered?

What was the overall context? Why was this initiated?

- Bangor, ME region saw a **high rate of patients with chronic disease** compared to state and national averages, with a small portion of the population accounting for nearly all healthcare expenditure in the region



Who was involved in initiating the change?

- **EMHS** leads both Bangor Beacon Community program and Pioneer ACO
- **12 engaged partners** include: Eastern Maine Medical Center, Penobscot Community Health Care, St. Joseph Healthcare, the Acadia Hospital, HealthInfoNet, Eastern Maine Community College, Eastern Maine HomeCare, Community Health and Counseling Services, Ross Manor, and Stillwater Health

How were people brought together? What circumstances helped facilitate that?

- EMHS received a 3-year \$12.7m grant from the **Office of the National Coordinator for Health Information Technology** to found the BBC program in May 2012
- **Center for Medicare and Medicaid Innovation** selected EMHS to be a Pioneer ACO in January 2012



2 What was the scope of new care delivery model?

Description

Size of population targeted

- Bangor Beacon Community program affected **53.7k patients**
 - **1,200 patients** enrolled initially in primary care management model
- Pioneer ACO will initially focus on **22k Medicare beneficiaries** but aim extend care delivery model to service all patient sub-populations

Geographic Scope

- Bangor hospital service area covers **Piscataquis, Hancock, Waldo, and Somerset counties** in Maine

Patient segments & pathways

- **Clinical focus areas** include diabetes, cardiovascular care, asthma, COPD, mental health, and immunizations
- **Nonclinical focus areas** include utilization and patient-report, measurement, disparities, and safety

Providers involved

- **Eastern Maine Healthcare Systems** is the lead grantee of the Bangor Beacon Community and initial applicant for CMS Pioneer ACO designation
- **3 hospital partners**, Eastern Maine Medical Center, Inland Hospital, and TAMC (all part of EMHS) are involved in initial BBC program
 - Beacon LLC expanded to include total of **9 hospitals** operating as Pioneer ACO
- **4 Federally Qualified Health Centers**

3 What were the goals of the new care delivery model?

	Description
Patients	<ul style="list-style-type: none">To promote patient self-management and empower patients as a member of their care coordination team
Quality	<ul style="list-style-type: none">To improve management of chronic conditions through information exchange, telemedicine, medical home model and patient safety
Costs	<ul style="list-style-type: none">Reducing costs associated with hospital admissions and emergency department visits by increasing the quality of care for high-risk patients
Population health	<ul style="list-style-type: none">To improve population health through proper immunization and sharing of immunization data among providersReduce variation in the delivery of evidence-based medicine and improve care quality for the community
Health IT	<ul style="list-style-type: none">To leverage existing statewide health information exchange to build an integrated organization to test new payment models and be accountable for the care of their populationIncrease meaningful users of HIT to 60% within the community
Sustainability	<ul style="list-style-type: none">Project will focus on producing systematic changes with sustainable and positive results for the community

SOURCE: Eastern Maine Healthcare Systems Grants -- Award Summary,

4a Health information technology is a crucial enabler for extension of the primary care workforce

1. Enhancing health information technology infrastructure

- Broadening reach of **HealthInfoNet**, statewide health information exchange
- **Connecting major health systems**, behavioral health facilities, LTC facilities, homecare, FQHCs
- Adding **functionality to send notifications** to provider or care manager
- Integrating **behavioral health data** in HealthInfoNet

2. Care coordination through extension of PCP workforce

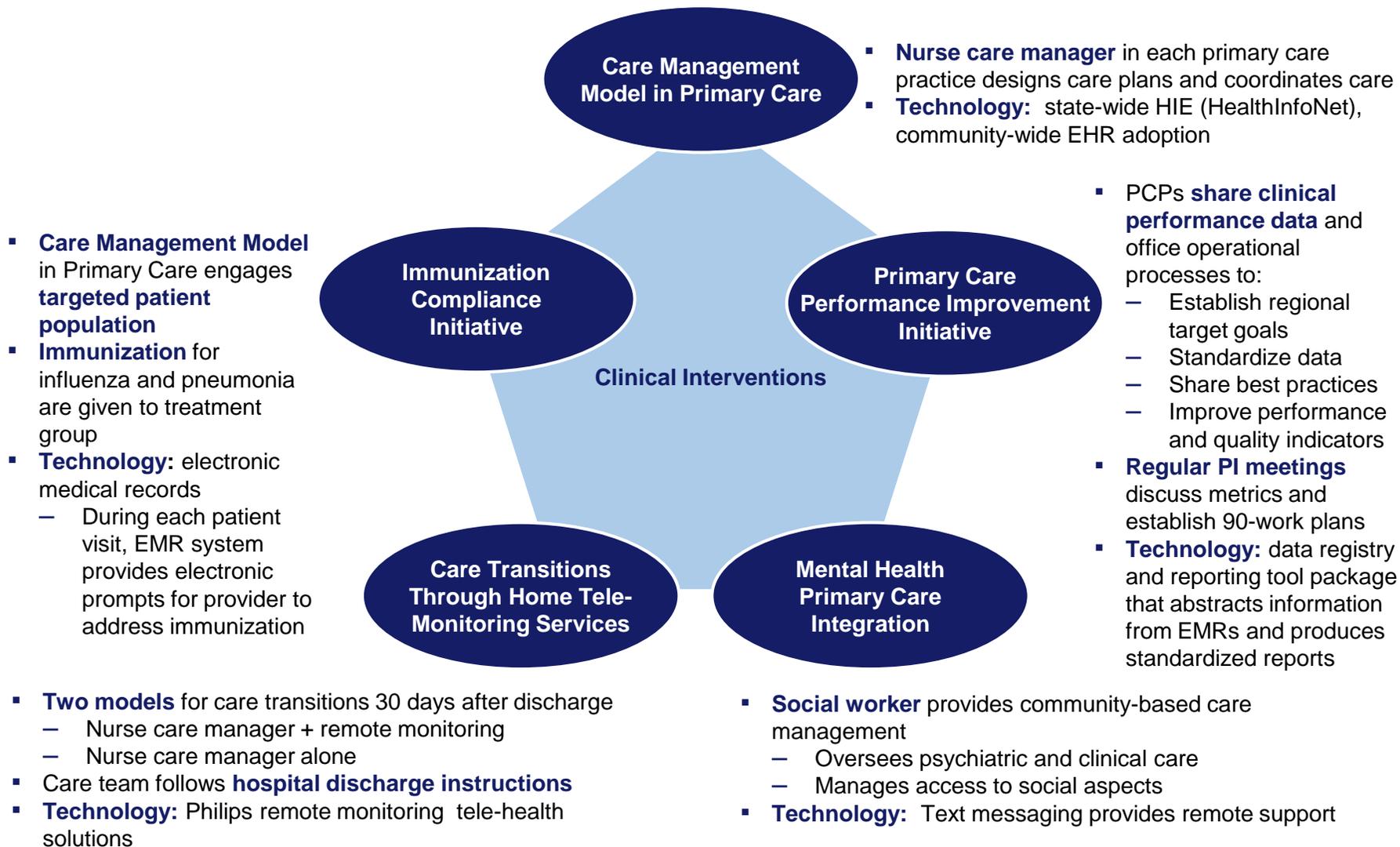
- Expanding reach of primary care through a network of technology-supported **nurse care managers**
- Managers utilize **electronic health records** to capture and access and track patient information and monitor patients via electronic home monitoring
- Enhancing **performance improvement efforts** of PCPs through sharing clinical performance data and office operational processes
 - Participants extract and share performance reports from practice EHR, which are stratified by region

3. Test mobile health innovation

- **mHealth**: Exploring ways to extent the reach of care coordinators to patients by using remote monitoring technology to monitor patients after release from hospital to reduce avoidable readmissions
 - Providing texting support to mental health patients
- **Telemonitoring project**: Care team tracks patient vitals on a daily basis through devices such as automated medication dispensers and other monitors
 - Homecare agencies and care coordinators collaborate to monitor patients at home and collaborate to identify warning signs
 - Care coordinators have been able to telephonically do medical reconciliation with the patients and homecare nurse

SOURCE: Office of the National Coordinator for Health Information Technology: Bangor Beacon Community, December, 7, 2012.

4b Clinical transformation takes place through five targeted initiatives, each supported by IT infrastructure



SOURCE: Office of the National Coordinator for Health Information Technology: Bangor Beacon Community, December, 7, 2012.

4c Care Management Model in Primary Care



Care delivery process

Patient ID/enrollment	Initial assessment	Care plan	Monitor/outreach	Ongoing care
<ul style="list-style-type: none"> Identify high risk/high cost chronic conditions patients (diabetes, CHF, COPD, asthma) with: <ul style="list-style-type: none"> At least one hospital admission, ED, non-urgent care/walk-in care visit due to condition in last 6 months Other disease-specific measures 	<ul style="list-style-type: none"> PCP takes clinical lead Utilizes and updates state-wide health information exchange, HealthInfoNet Nurse care manager assesses need to involve other clinical staff or care team 	<ul style="list-style-type: none"> Nurse care manager develops care plan Coordinates care team when necessary <ul style="list-style-type: none"> Mental health care management team Home health services Inpatient care management team In-clinic patient education is provided by the nurse care manager 	<ul style="list-style-type: none"> Telemedicine allows remote monitoring <ul style="list-style-type: none"> Patients upload health vitals daily Alerts are sent to nurse care manager Nurse care manager provide telephone consultation and health coaching Dispatches relevant care team when necessary 	<ul style="list-style-type: none"> Patients are encouraged to self-manage chronic condition, as per in-clinic education Nurse care managers are available for telephone consultation when needed 

Technology integration

- Community-wide HIE** provides care transition infrastructure between hospitals and primary care practices, providing real-time information to care managers on admissions and emergency department visits
- EHR adoption across the region** includes standardized data collection through care manage encounter forms
- Secure e-mail** connects providers, nurse care managers, and patients

SOURCE: Bangor Beacon Community 2012 Annual Report, Bangor Metro, "Healing at Home," May 2012.

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5 What were the operational changes in how care is delivered?

Primary care

- **Practice redesign and care coordination:** each primary care practice has the support of at least one **nurse care manager** who:
 - Develops care plan
 - Assesses the need to incorporate other staff members
 - Coordinates the transition of care for those patients
 - Provides patient education

Community care

- **Nurse care manager** oversees **at-home care**
 - Telephone consultation allows self-management of conditions
 - Involves PCP or other relevant care teams when necessary

Acute setting

- **Automated electronic alert** is sent to **nurse care managers** following ED visit or hospital admission
 - Provides clinical support
 - Coordinates care transition when timing is appropriate
- PCP is then notified by the nurse care manager



Addition of nurse care managers is the key operational change enabling care delivery model

6 How were key success factors addressed?



Organization and Accountability



Clinical leadership and culture development



Information sharing



Aligned incentives



Patient engagement

Summary of key elements

- Nation-wide Beacon community programs share general design
 - EMHS was lead ONC grantee and the initial Bangor health system recognized as an CMS Pioneer ACO
-
- Effective use of leadership groups
 - Care Manager Forums are held bi-weekly and address issues of communication, technology, and process barriers
 - Statewide Advisory Committee shares best practices
-
- Maine already used statewide health information exchange system, HealthInfoNet
 - Increased functionality of EHR, clinical data sharing capabilities, and telemedicine initiatives were enabled by ONC's \$12.7m grant
-
- No financial risk to BCC participants
 - ONC grant funded program activities
 - BBC program did not involve change in payment model
 - ACO structure is utilized to provide financial sustainability by holding provider accountable for total care costs
-
- Continuous patient engagement is ensured through in-clinic patient education, at-home consultations, and encouraged self-management
 - Bangor Beacon Patient Advisory Group provides

6 How does the payment model align incentives?

Relevant questions

Overview and guiding principles

- Initial BBC program did not include a payment-based element
- EMHS participation in CMS Pioneer ACO program began on January 1, 2012
- Renamed ACO Beacon LLC and extended ACO participation to other regional hospitals, including a total of six hospitals, as of January 2013

Aligning individual incentives

- Beacon LLC, the ACO entity, is held responsible
- Provider is accountable for total cost of care by Medicare beneficiaries
- Pioneer ACO sees increased accountability over 3 years:
 - Year 1: upside-only savings of 50%
 - Year 2: upside and downside savings/losses of 70%
 - Year 3: ACO migrates to capitation model and receive 50% revenue from risk share contracts

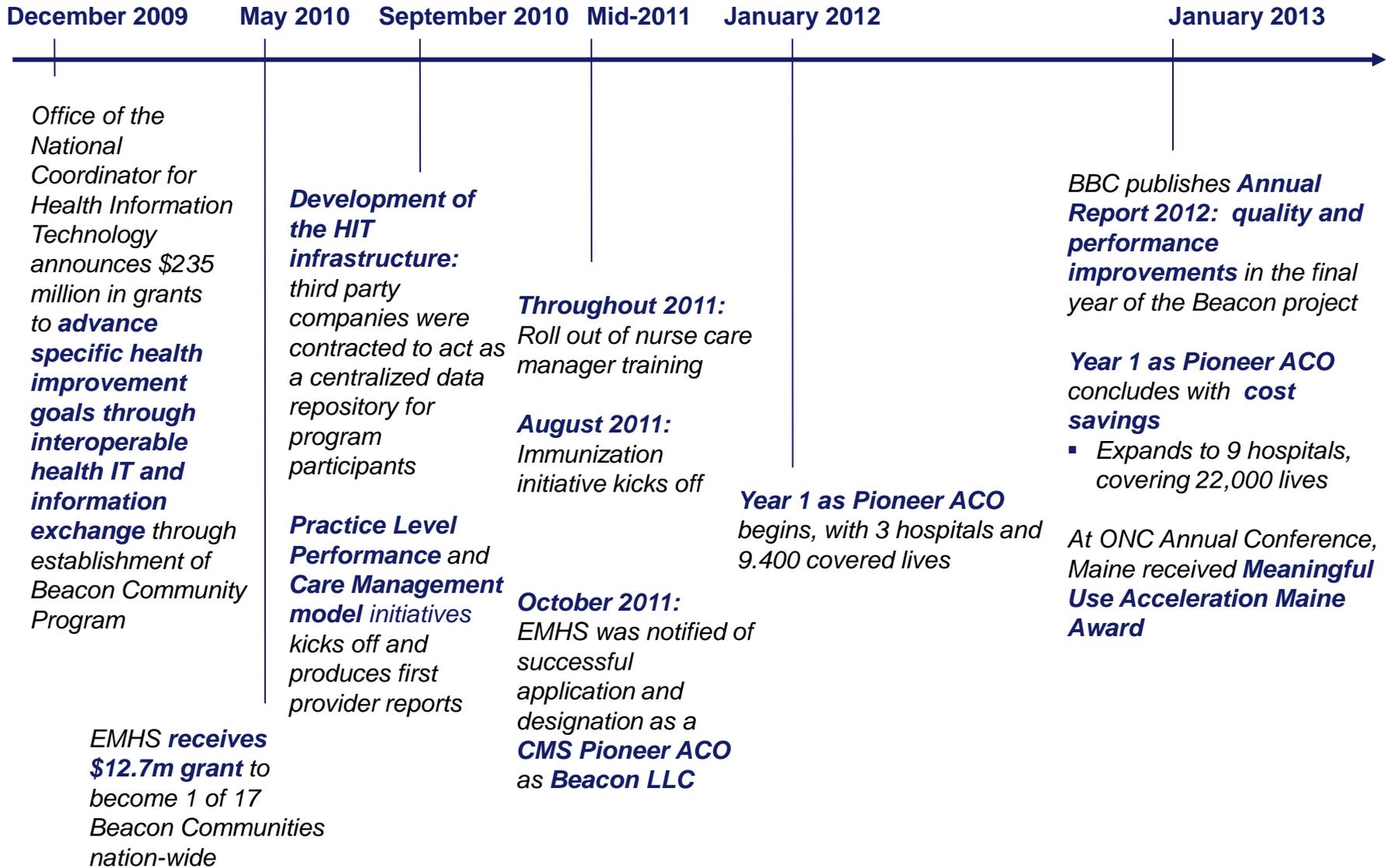
Mechanisms to mitigate volatility

- Accountability is increased incrementally over 3-year period
- First year of upside-only shared savings allows adjustment period, provided the ACO achieves savings rate of ~2.5%

Operationalizing the payment model

- EMHS applied for to be a Pioneer ACO in July 2011
- Received notice of Pioneer Designation in October 2011
- Began operating as Beacon LLC in January 2012

7 How was the care model put in place?



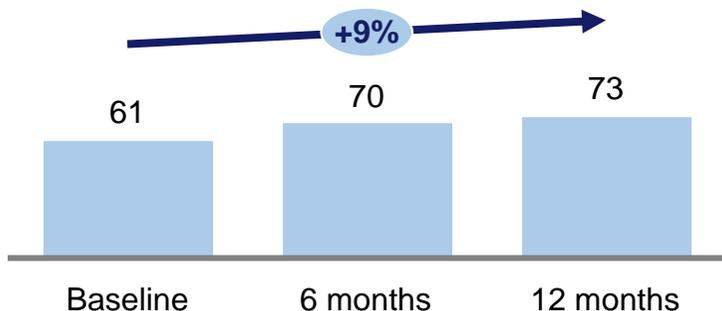
SOURCE: US Department of Health & Human Services: HealthITBuzz, ONC Beacon Communities, December 2, 2009, Bangor Beacon Community Program Annual Report 2012.

8 What was the impact in terms of quality and costs?

Improved chronic heart failure outcomes¹

Blood pressure control for CHF patients

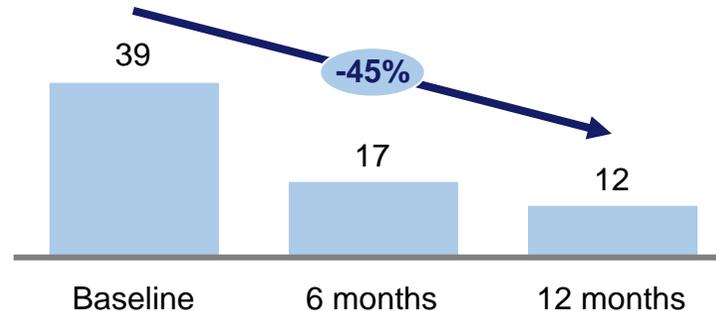
Percent of CHF patients with BP <130/80



Improved diabetes outcomes¹

HbA1C levels in diabetes patients

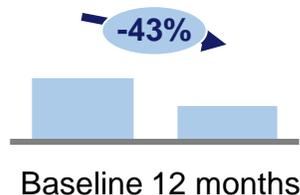
Percent of diabetes patients with HbA1C >9



Reduced healthcare utilization¹

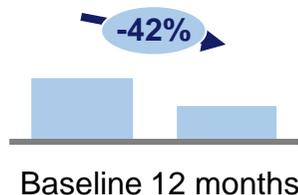
Emergency dept visits

Total ED visits



Hospitalizations

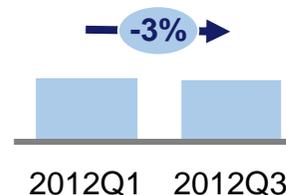
Total hospital admissions



Cost savings

Pioneer ACO cost savings

Percent reduction in costs



- 14 out of 32 ACOs managed to generate cost savings in the first three quarters
- Beacon LLC ranks 7th out of 32 participants by reduction in cost

¹ Results exclude patients loss to follow-up (16.3% of patients of total enrolled patients at six months; another ~22% at 12 months). Primary reasons for loss: death, unable to contact patient, patient discharged from practice for compliance issues, patient in skilled nursing facility, patient unable to comply with protocol

SOURCE: Eastern Maine Healthcare Systems' Annual Report, 2012, Office of the National Coordinator for Health Information Technology; Bangor Beacon Community.

9 What advice would you give to organizations who are designing a new care delivery model?

Do's

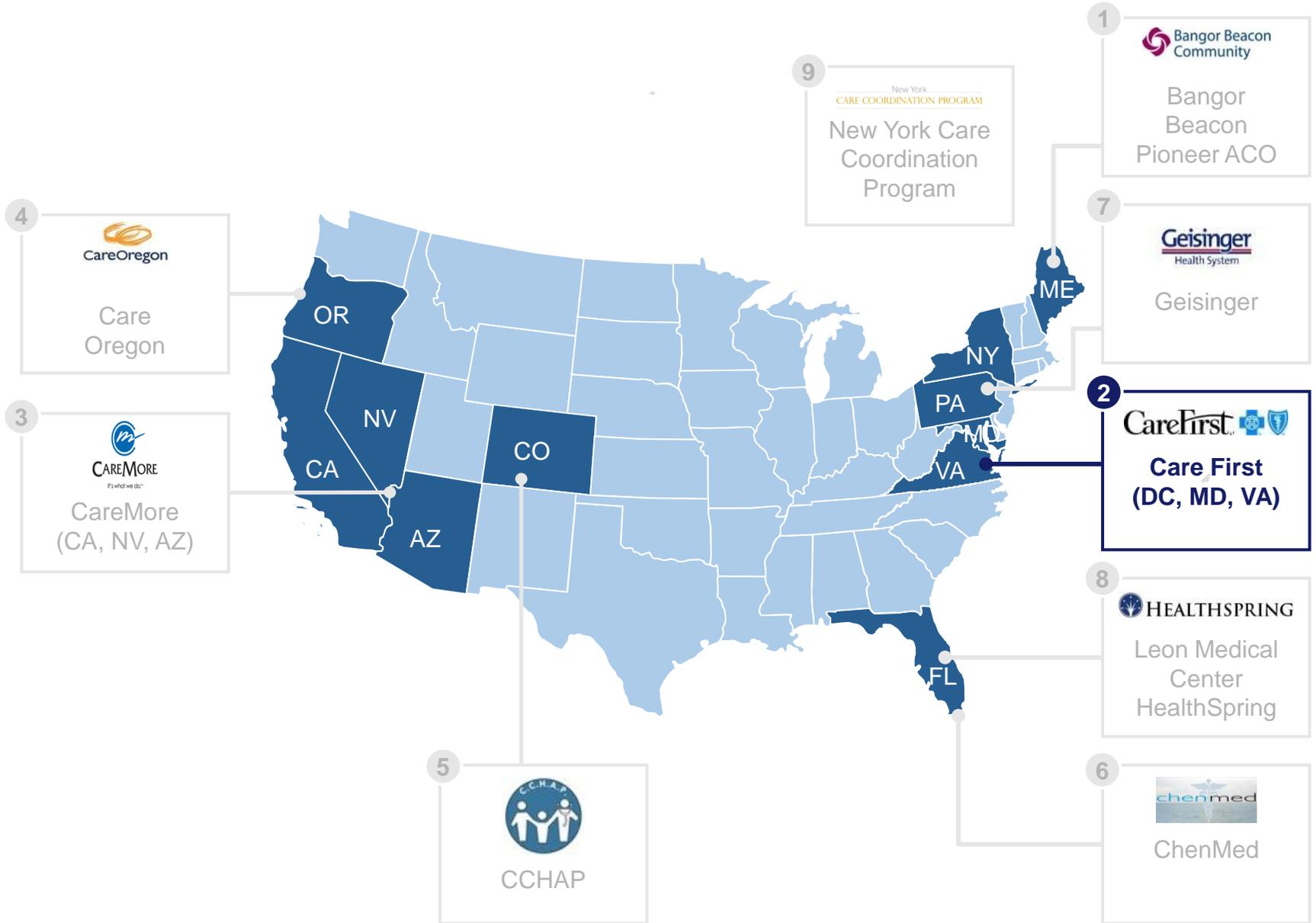


- Leverage existing healthcare information technology:
 - Increase adoption and usage of existing infrastructure
 - Supplement functionalities to enhance provider care coordination and patient engagement
- Incorporate non-physician providers and paraprofessional into care teams
- Establish robust forums and focus groups to ensure patient and clinical engagement

Dont's



- Restrict program enrolment eligibility by insurance coverage, as may affect provider buy-in
 - Other programs targeting Medicaid enrollees were challenged by negative provider attitudes



Overview: CareFirst

Why was a change in care delivery considered?

- CareFirst is a large, non-profit health insurer covering 3.4 million people in the mid-Atlantic region of Maryland, DC and Northern Virginia
- Patient-centered medical home model introduced in 2011 and is open to all CareFirst members but the operational focus is on patients with multiple and/or complex long term conditions and those at high risk of developing complex long term conditions

What was the scope of the care model?

- Serves a general population of 3.4m with a \$5.6bn spend in 2010
- Focus on two patient groups:
 - Those with multiple or complex long term conditions: 8% of CareFirst population
 - Those at a high risk of developing long term conditions: 20% of CareFirst population

What were the changes made?

- Designated-PCP, medical home model
- Patients have a free choice of provider
- Each Medical Home is clinician-led, consisting of 5-15 PCPs (optimal size for accountability)
- High-risk patients are given Care Plans overseen by PCP, Care Coordinator and community-based care team

How was the care model put in place?

- PCMH and related 'Healthy Blue' product (for consumers) were introduced in early 2011
- This program is the first phase of a multi-year project to identify and address the root causes of suboptimal care quality and cost growth

How did payment reform support care model?

- CareFirst uses a mix of FFS and incentive payments
- Each medical home is allocated an indicative budget against which savings/deficits are measured
- Patients are offered incentives for adherence to care plans and lifestyle guidance and appropriate use

What was the impact in terms of quality and costs?

- Model introduced in 2011 and impact not yet measured

1 Context: Why was integrated care considered?

What was the overall context for integrating care? Why was this initiated?

- CareFirst is a large, non-profit health payer covering 3.4 million people in the mid-Atlantic region covering Maryland, DC and northern Virginia
- The Patient-Centered Medical Home program (for primary care providers) and related 'Healthy Blue' product (for consumers) were introduced in early 2011 with the aim of tackling per capita health care costs close to the top of national rankings and sustained, steep increases in spend
- The initiative is in part a response to earlier attempts to create 'cost-sensitivity' in consumers through cost-shift, high-deductible plans which may have led consumers to delay seeking care leading to high future costs
- This program is the first phase of a multi-year project to identify and address the root causes of suboptimal care quality and cost growth

Who was involved in initiating the change?

- The Program is led by a single payer and authorized as a single payer program but all elements of the program are broadly applicable to Medicare and Medicaid public payer programs, to create a unified, public-private system and incentive structure covering the majority of the population of the Maryland, DC, northern Virginia region
- The Program is focused on primary care providers but involves all other parts of the health care system including hospitals, clinics, pharmacies and allied providers



2 What was the scope of integrated care?

Description

Size of population targeted

- The program is open to all 3.4m CareFirst members except those of Medicare supplemental benefit contracts (where Medicare fee schedules apply)

Spend targeted

- CareFirst medical care spend was \$5.6bn in 2010
- The Medical Home system targets all health care spending for enrolled individuals

Patient segments & pathways

- All eligible patients are encouraged to join the Medical Home/Healthy Blue program but within the program, the focus is on two patient groups in particular:
 - Those with multiple or complex long term conditions - 8% of CareFirst population
 - Those a high risk of developing long term conditions – 20% of CareFirst population

Providers involved

- 80% of providers in the CareFirst region (Maryland, DC) participate in one or more of CareFirst's provider networks

Payers involved

- Single payer involved but potentially extendable to regional Medicare/Medicaid programs
- In the future, CareFirst will encourage employers purchasing their health insurance products to motivate their employees to choose PCPs enrolled in the PCMH program through reductions in cost-sharing requirements and premium contributions

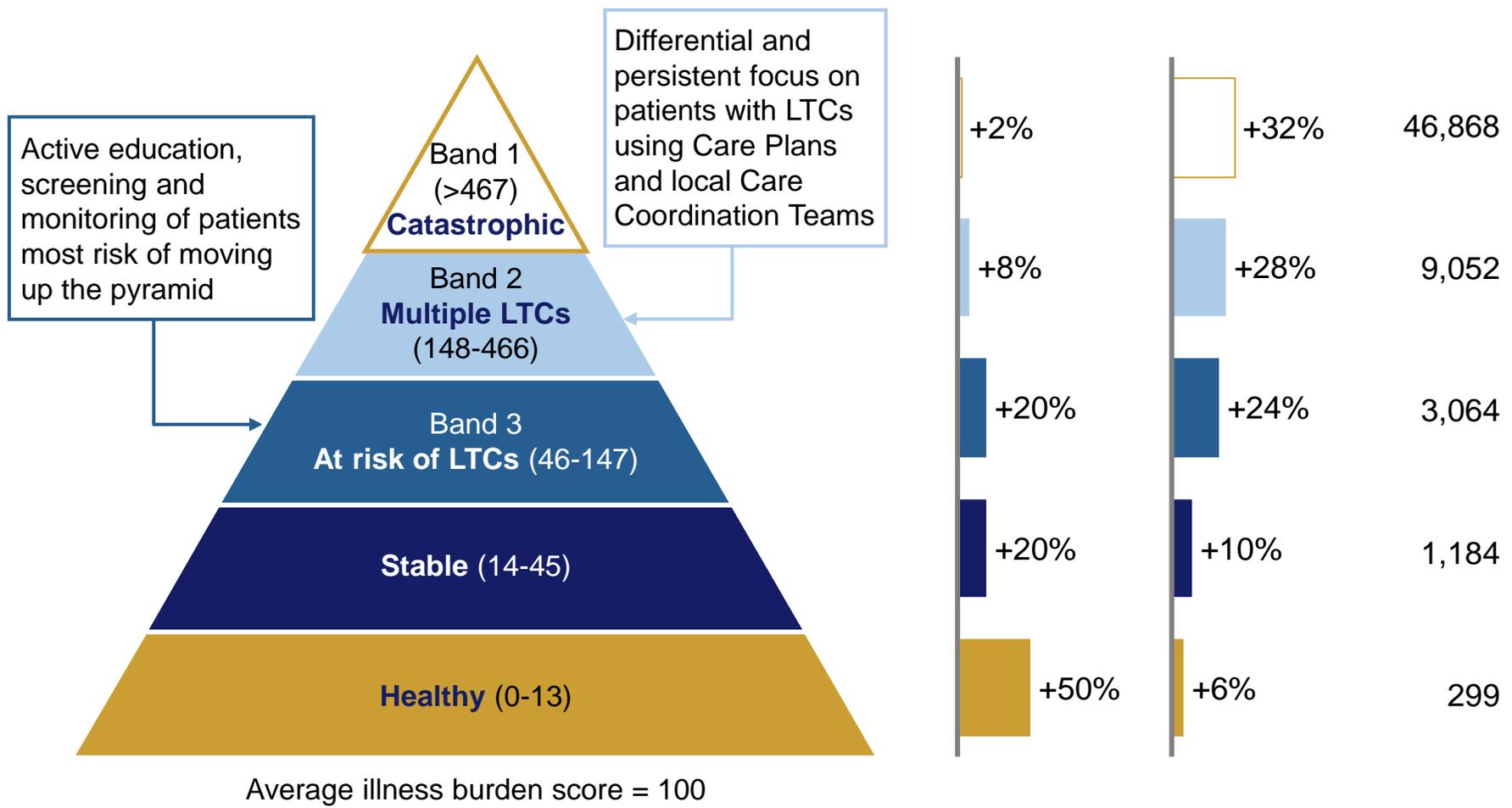
3 What were the goals of integrating care?

	Description
Patients	<ul style="list-style-type: none">▪ To create meaningful incentives for patients to:<ul style="list-style-type: none">– Select and use a PCP– Follow healthy lifestyles and reduce risk– If relevant, engage and comply with their Care Plan
Primary care physicians (PCPs)	<ul style="list-style-type: none">▪ PCPs should differentially and persistently focus on the health outcomes, treatment patterns and Care Plans of the most resource intensive patients:<ul style="list-style-type: none">– Those with multiple or complex long term conditions– Those at high risk of developing a long term condition▪ PCPs should be able to see and manage the downstream costs and quality implications of their referral decisions
Quality	<ul style="list-style-type: none">▪ Measures of quality to be built in from the beginning to ensure that cost control efforts do not result in suboptimal quality▪ For patients with long term conditions, integration and engagement between patients, primary care providers, specialist providers and a care coordination team are seen as critical components of quality
Costs	<ul style="list-style-type: none">▪ No explicit targets but overall goal to create a sustainable system which controls health care costs
System working	<ul style="list-style-type: none">▪ To create networks within primary care – the Care Coordination Team – and between PCPs and specialists

SOURCE: Patient-Centered Medical Home Program: Program description and guidelines, CareFirst, 2011

4 Operational focus of PCMH/Healthy Blue program

CareFirst patients by Illness Burden Score, 2009



LTC = long term condition

SOURCE: Patient-Centered Medical Home Program: Program description and guidelines, CareFirst, 2011

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5 Ten design elements of the PCMH model

Medical Care Panels

- Primary care physicians should organize into Medical Care Panels (the panel is the “Medical Home”) of at least 5-15 PCPs to share experience and to create patient cohorts of sufficient size to justify investment in care coordination resources and to create confidence in composite quality scoring

Patient assignment to Medical Care Panel

- CareFirst members will be assigned by Medical Care Panels based on patient choice or prior 2 years claims history if no active choice of PCP has been made
- If the patient has not designated a PCP and has not visited a PCP in 2 years no attribution will be made

Patient risk stratification

- Individual patients are assigned an Illness Burden score (see previous page) using a Diagnostic Cost Grouper and these are aggregated to provide a cohort pyramid at Medical Home level

Indicative global capitation budget

- An indicative “global capitation” budget is calculated for each Medical Home based on the claims history of the patients in the panel multiplied by the overall medical trend factor
- As patients incur costs through the year, these are debited from the indicative budget

Referral management

- CareFirst provides Medical Homes with information on specialist service costs and quality
- Medical Homes are expected to create their own specialist networks and partners, to agree care pathways and, in time, these are expected to form the basis for bundled payments reimbursement systems

Care Plans and Care Teams

- PCPs should create Care Plans for all patients in Band 2 and some in Band 3 using tailored templates covering diabetes, asthma, COPD, CAD, CHF, hypertension, neck and back pain, osteoarthritis and childhood obesity
- Local Care Coordinators/Care Coordination Teams will be assigned to each Medical Home to support Care Plans

Electronic Health Records

- CareFirst will maintain a single, longitudinal electronic Member Health Record containing information from all care settings and providers and available to the Medical Home

Quality measurement

- Quality measurement and scoring is based on 5 categories: (1) Engagement with patients in need of Care Plans, (2) Appropriate use of services (ER, admissions, readmissions, diagnostics), (3) Effectiveness of care (HEDIS), (4) Patient access to primary care services, (5) Structural capabilities

Incentives

- Outcome Incentive Awards available to Medical Homes based on savings achieved (compared to indicative budget) and completion of all program requirements

Participation rules

- PCP participation in the PCMH model is voluntary but those enrolling in the program are required to follow the regulations and processes set out in the program in order to be eligible for the participation fee

6 How were key success factors addressed?



Organization and Accountability



Clinical leadership and culture development



Information sharing



Aligned incentives



Patient engagement

Summary of key elements

- CareFirst closely monitors the activities and capitated spend of Medical Homes to ensure compliance with the regulations and processes
- PCPs are required to organize into Medical Homes of 5-15 physicians who are responsible for activities and performance
- Where primary care groups of >15 PCPs want to join the program they divide into units of 10-15 to ensure personal accountability
- The program uses a single, comprehensive, longitudinal patient record visible to payers and providers
- Pre-formatted Care Plan templates help to promote shared best practice in care planning design
- Participating physicians receive incentives based on savings vs indicative budget and achievement against process and outcomes based targets
- Patients receive incentives – based on reduced co-payments or deductibles – for enrolling in a Medical Home, complying with the Care Plan and following risk mitigation guidance

6a Performance incentives for primary care physicians

Additional fee-based compensation for primary care providers who enroll in the Medical Home program:

Basic fee schedule

- The primary care service fee schedule and allowances are increased by 12% for all Primary Care Physicians (PCPs) who join the program

Care Plan fees

- PCPs receive an additional service fee of \$200 for each Care Plan created plus \$100 for ongoing maintenance of Care Plans

Performance incentives

- Outcome Incentive Awards worth an additional 20-60% of income for achievement of overall cost and quality targets for enrolled patients



6b Patient engagement and incentives

Core principles of the Healthy Blue program for members:

Health risk appraisal

- Annual baseline health risk appraisal linked to financial rewards for behavioral change achievement of healthy lifestyle targets

Access to primary care

- No co-payments, deductibles or other cost barriers to primary care services including screening, preventative health services and medicines for the management of long term conditions

Sustained primary care relationships

- Members should receive meaningful incentives to form strong, sustained relationships with a single Primary Care Physician (PCP) of their choice: currently ~30% of CareFirst members do not have a designated PCP

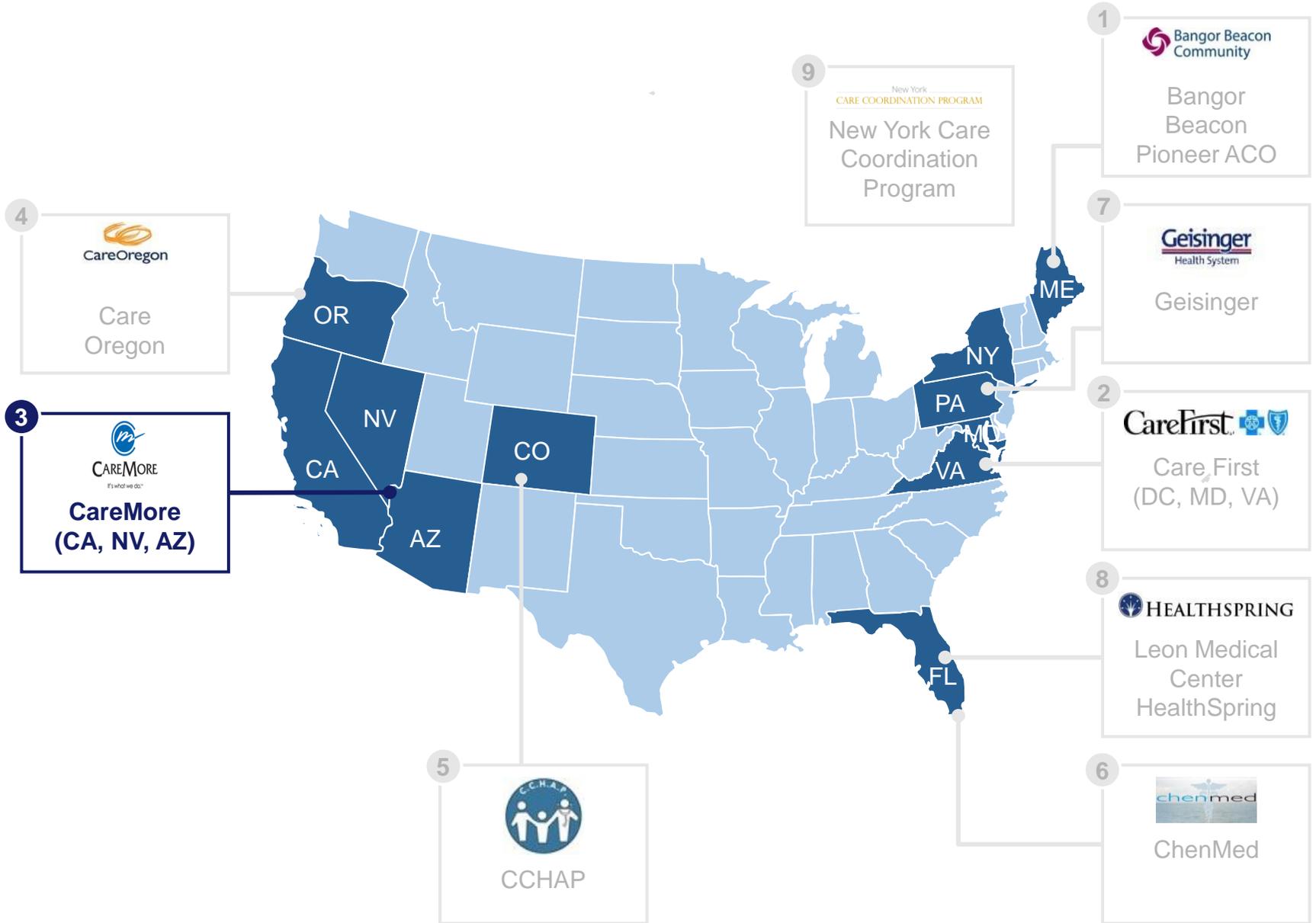
Compliance with Care Plan

- Financial incentives for people with long term conditions to follow Care Plans developed by their PCP and to take steps to reduce their health risks: e.g. through waiving co-payments for specialist services for those meeting compliance targets

Complete benefit plan

- Benefit plans should be comprehensive and no savings should be achieved by curtailing or creating holes in coverage that inhibit implementation of the Care Plan

CareMore



Overview of the CareMore delivery model

Why was a change in care delivery considered?

- CareMore started in 1993 as a medical group providing wellness-focused care for seniors, becoming a Medicare Advantage managed care plan in 1997, operating 26 care centers across CA, AZ and NV
- It was acquired by WellPoint in 2011 who plan to expand to VA and NY in 2013
- It provides nurse-led, tiered and coordinated care at centralized sites supported by 'extensivist' physicians in hospitals

What was the scope of the care model?

- Focused program for 40% frailest Medicare and Dual Eligibles with complex chronic conditions, e.g.:
 - Diabetes
 - ESRD
 - Hypertension
 - CHF
 - COPD
- ~68,000 enrolled patients
- CareMore deliver out-of-hospital care with partners for other services

What were the changes made?

- NPs provide personalized, prescriptive disease management programs tailored to acuity levels
- Care is delivered at centralized clinics by multi-disciplinary teams, supported by a robust technology platform
- Extensivists based in hospitals focus on avoiding admissions, readmissions and managing transitions

How was the care model put in place?

- The CareMore system has spread gradually over 20 years from its base in Los Angeles/ Orange County
- Care is standardized using pathway-based protocols covering a wide range of different conditions and scenarios
- Each patient has an EMR visible to all providers in the network – high use of remote monitoring

How did payment reform support care model?

- Risk-adjusted capitation-based Medicare Advantage plan
- CareMore focuses on the 40% most frail Medicare patients which attract a risk premium
- CareMore margin is driven by investments in upstream care to reduce downstream costs

What was the impact in terms of quality and costs?

- Total member costs 18% below national average for patient cohort
- Hospitalization rate 24% and length of stay 38% below national averages
- Amputation rate for people with diabetes 60% below national average

1 The CareMore model has evolved over the last 15 years to optimize care under a capitated risk-adjusted payment model (MA)

What was the overall context? Why was this initiated?

- The CareMore program was developed in the mid-1990s by a physician – gastroenterologist Dr Sheldon Zinberg – who was looking for way round the increasing barriers to referrals to his multi-specialty physician organizations, presented by the growth in HMOs
- He devised a coordinated care program for frail, elderly patients that would provide primary-focused care on a capitated payment model
- CareMore evolved from primary care into a comprehensive Medicare Advantage program

Who was involved in initiating the change?

- CareMore grew out of a 20-FTE physician organization led by Dr Zinberg
- Private equity investment funded geographic expansion and CareMore was eventually acquired by WellPoint in 2011 for \$800m

How were people brought together? What circumstances helped facilitate that?

- The CareMore delivery model uses specialized care centers which offer an integrated range of services and ‘extensivists’ placed in hospitals to reduce admissions for CareMore enrollees and manage transitions of care
- CareMore partners with a range of other service providers in an informal network



2 CareMore is focused on the Medicare 40% highest risk cohort

	Description
Size of population targeted	<ul style="list-style-type: none">▪ Currently ~68,000 enrollees with plans to expand from CA, AZ, NV, to VA and NY▪ 20% of members are Dual Eligibles; 89% are >65 years old▪ Growth is determined by location of CareMore care centers (see page 29)
Spend targeted	<ul style="list-style-type: none">▪ Medicare Advantage risk-adjusted capitation payment
Patient segments & pathways	<ul style="list-style-type: none">▪ 40% highest-needs Medicare population – generally frail elderly with multiple complex conditions▪ Average MA patient risk score of 1.4 compared to 0.9 MA average
Providers involved	<ul style="list-style-type: none">▪ CareMore delivers comprehensive disease management at its 26 care centers and is part of a network of partner hospitals, outpatient centers, laboratories, dental practices, optometrists, skilled nursing facilities and urgent care centers
Payers involved	<ul style="list-style-type: none">▪ Medicare Advantage

3 What were the goals of the CareMore delivery model?

Description

Patients

- Provision of proactive, prevention and **wellness-focused disease management**
- Burden of non-compliance shifted to the provider- e.g. free transportation to services and extensive use of remote monitoring

Quality

- Quality of care is driven through the use of **standardized protocols** for a wide range of conditions and risk factors

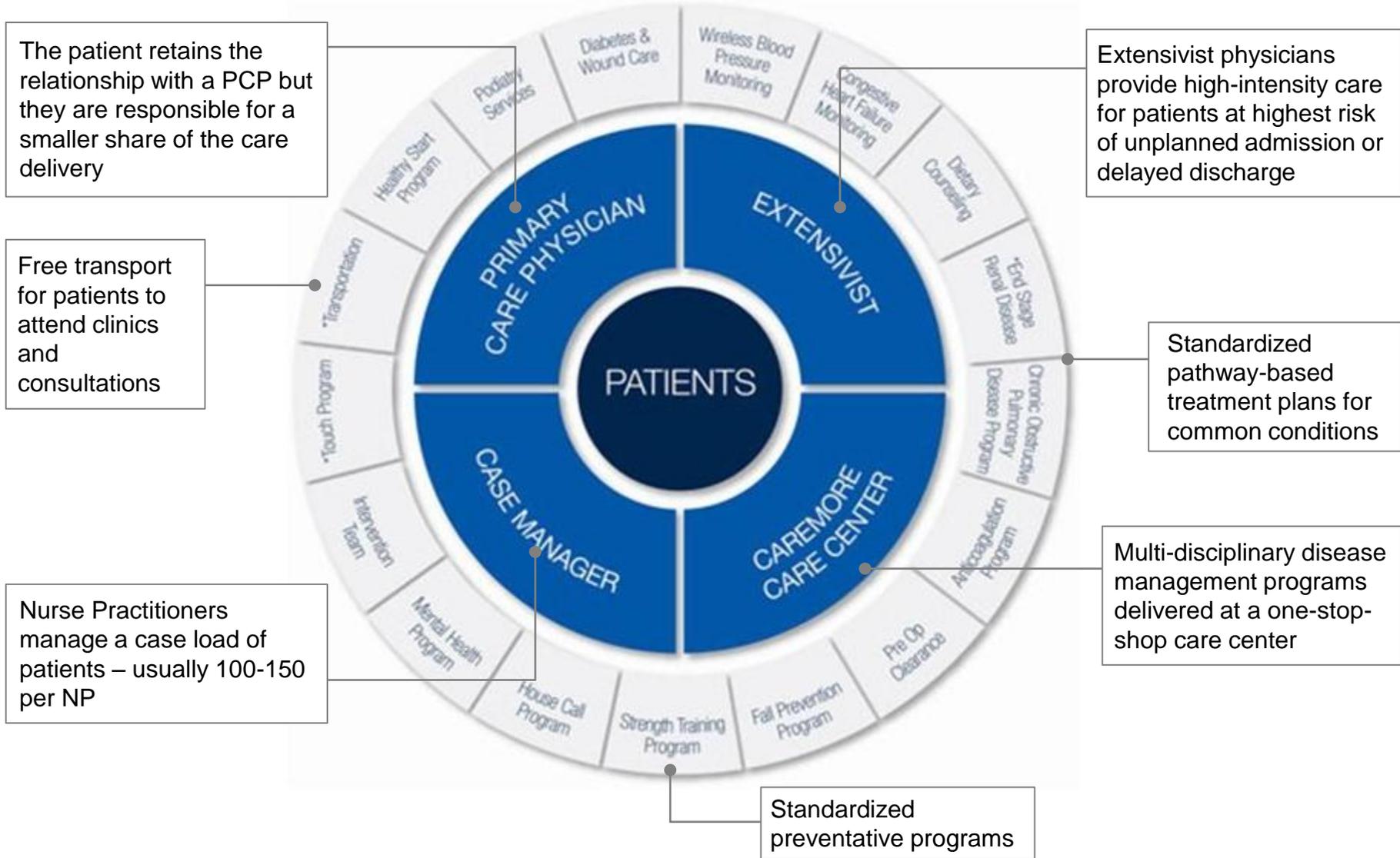
Costs

- Core objective is to **reduce ED visits and unscheduled inpatient admissions**

Physicians and clinical workforce

- **Nurse Practitioners** lead clinics and are responsible for case management
- **Social services SWAT team** - physicians, social workers, case managers, behavioral health professionals - support the patient/family in accessing needed social services, e.g. financial assistance, Medicaid coverage for board and care, and other challenges
- A **home team** visit patients in their own homes to understand issues affecting health and provide wrap-around support
- **Physician extensivists** actively lead care teams and personally manage admissions, readmissions and transitions:
 - Lead ambulatory multi-disciplinary care teams each responsible for 200-400 patients – team includes nurses, psychologists, pharmacists, therapists, social workers, podiatrists, dieticians and others
 - Conduct daily inpatient rounds of hospitalized members to coordinated transitions
 - Conduct weekly SNF (skilled nursing facility) rounds
 - Hold regular clinics for recently discharged members
 - Hold regular clinics for those at risk of hospitalization

4a The CareMore model provides coordinated, tiered disease management



SOURCE: AHRQ Innovations Exchange; Health Affairs 28(5), 2009; CareMore website; expert interviews

4b The CareMore model relies on a core set of enablers: prescriptive disease management, supporting IT and workforce redesign

Model Overview

- A PCP led model utilizing nurse practitioners to implement prescriptive disease management programs tailored to member acuity levels
- The CareMore clinic staff is supported by a robust technological platform that can remotely monitor members' metrics, identify potential areas of concern, and prompt clinic involvement
- CareMore achieves high member satisfaction through strong medical results and providing relevant services and benefits to the demographic to reduce the barriers to care

CareMore market characteristics

- Concentrated MA population
- Payer confidence in membership longevity

Member profile

- High medical cost in manageable diseases (i.e., diabetes)
- Suffering from advanced stages of one or multiple chronic conditions
- Require more guidance through healthcare system

Key Model Enablers

Prescriptive disease management program

- All members are enrolled into a disease program based on their primary condition
- Each program has levels of care pathways to directly and most appropriately address members' acuity levels
- The disease management programs dedicated NP's direct all of the program's members, but have access to all disease management resources and can collaborate with other programs' NPs for members with comorbidities
- These disease programs are continually revised to adopt clinically-proven best practices

Data infrastructure and system guiding

- Each patient has an EMR to provide transparency across providers and avoid unnecessary diagnostic testing
- Disease management programs have prescribed steps that the data system and EMR prompt the NPs to execute
- Remote monitoring of critical metrics for high acuity patients in necessary markets
- Identification of frail and chronically ill members needing intensive management through predictive models and data scans

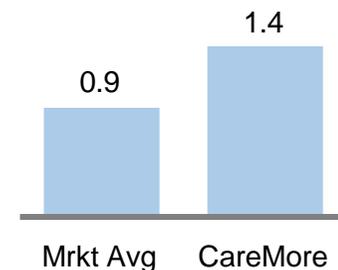
Extensivists and hospitalists placed in hospitals

- Able to identify if the patient's condition can be better served in a scaled nursing facility to avoid hospital admissions when possible
- Works with member's care manager during hospitalization to prescribe transitional care and better adapt care to patients

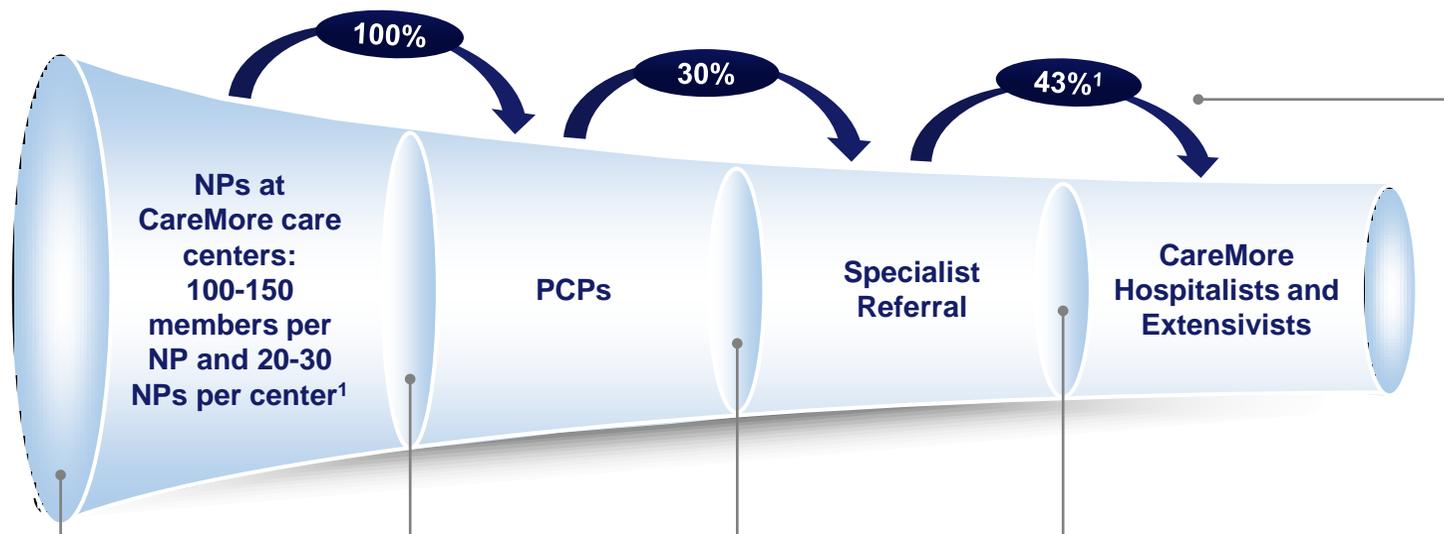
Model Impact

- Member costs are 18% lower than industry average¹
- 24% lower than average hospitalization rate with a 38% shorter than average hospital stays
- 60% lower than average amputation rate among diabetics
- 56% reduction in CHF hospital admits in 3 months
- 50% reduction in ESRD hospital admission rates in 5 months
- Higher average MA risk score

MA risk score comparison



4c CareMore's model creates a funnel that removes the need for patients to see more acute and costlier care



- Replace physician labor with skilled, allied health professionals such as NPs, therapists and dieticians
- Early intervention to prevent acute episodes through proprietary resources and predictive modeling
- Implementation of personalized care programs that apply proper attention to the most acute membership, while maintaining all members' acuity levels

- Develop relationships with PCP population to create partnerships with patients' trusted health ally to encourage potential members to join CareMore
- Leverage PCPs to accomplish monitoring of non-frail members to proactively identify at-risk members and encourage management conditions to prolong the onset of frailty

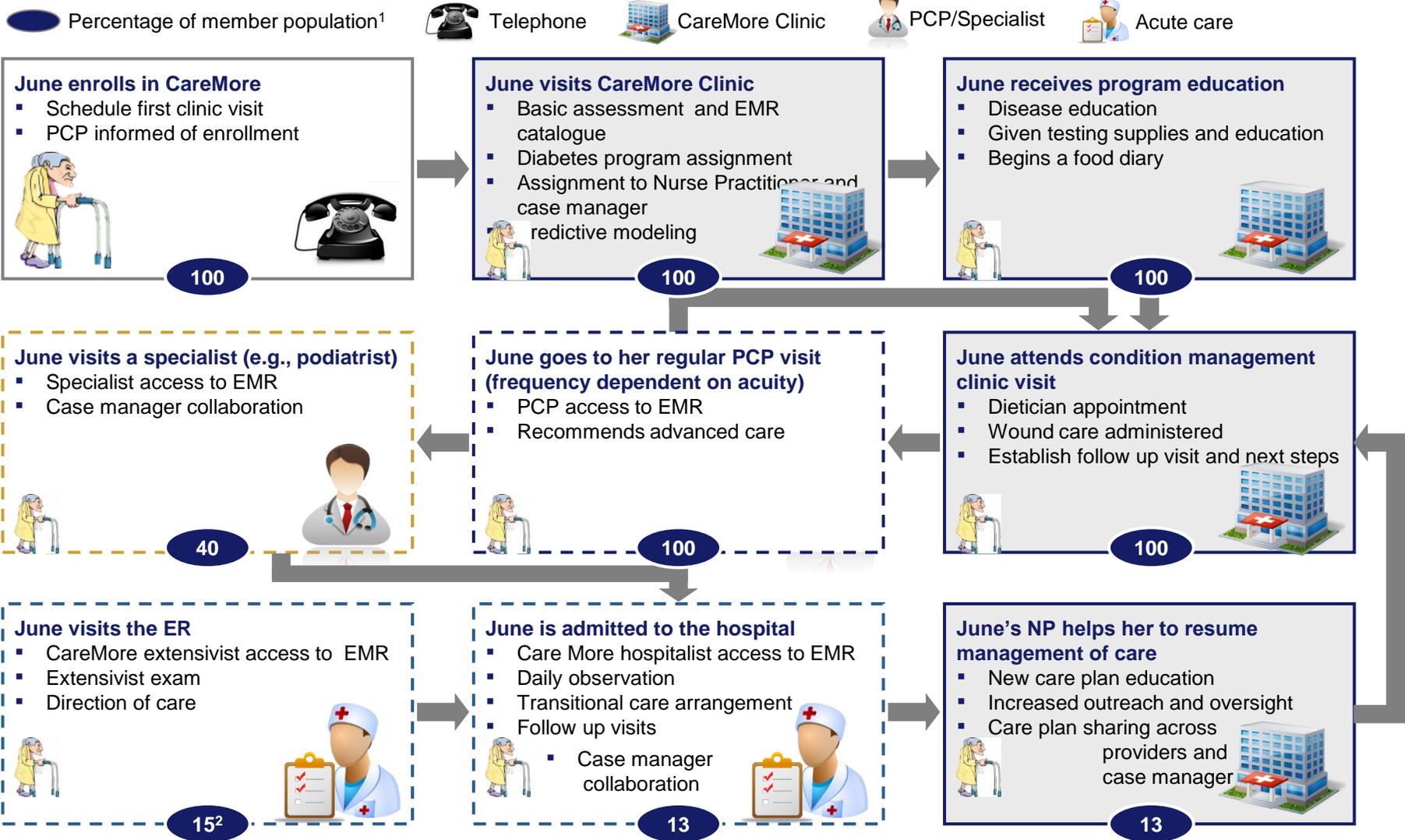
- Diagnosis additional member conditions and degree of acuity
- Recommend increased oversight and care management

- Utilize clinically-proven pathways to downgrade and discharge patient correctly and quickly
- Work real-time with case managers to set up effective and timely transitional care
- See patients 3-5 days after IP discharge to monitor transitional care effectiveness
- Manage disease in early stages

Caremore extensivists also help to lower admit rate through determining when a patient can utilize specialized nurse treatment

¹ Expert interviews and California member reports benchmarking; actual numbers will be dependent on the chronic disease prevalent in the member population, the member population's acuity across diseases, and the frequency of member clinic visits

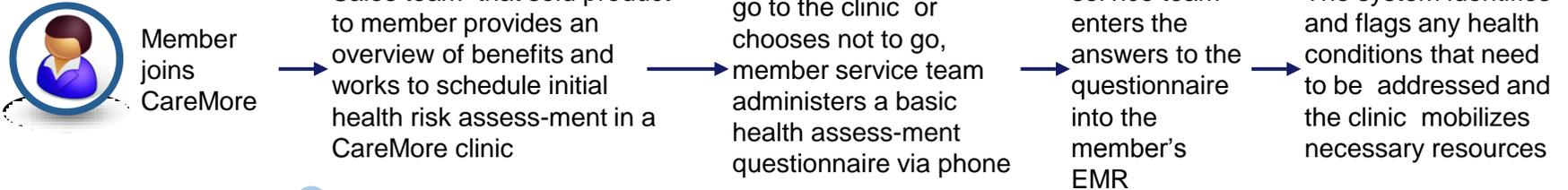
4d June's journey as a CareMore member: a personalized care plan helps maintain her acuity level and avoid advanced care



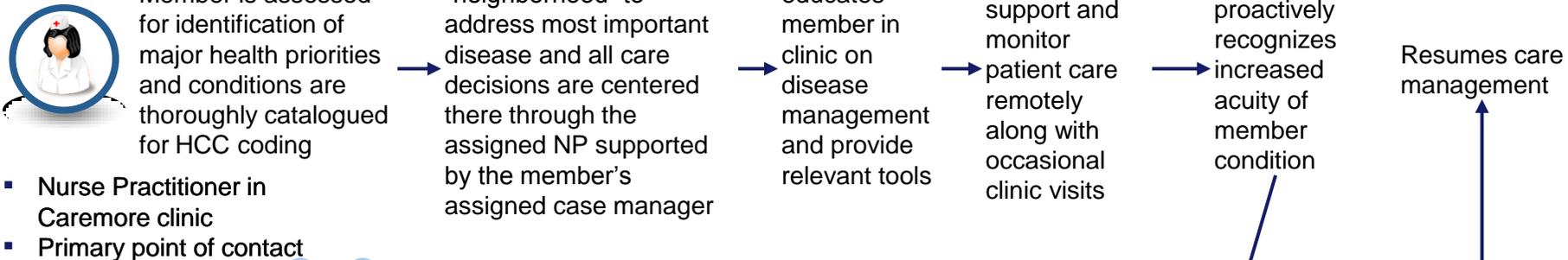
1 Benchmarked based on California enrollment report and expert interviews
 2 BCBSM current 295 per 1000 members after applying CareMore 50% reduction

5a There are six stages of support in a CareMore patient journey (1/2: primary care activities)

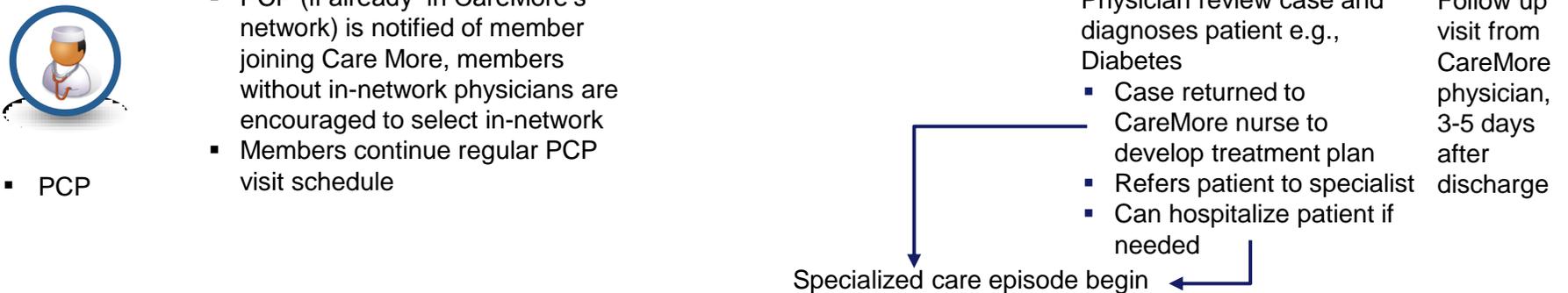
1 Salesteam and member service team onboard member



2 Standard Caremore Approach

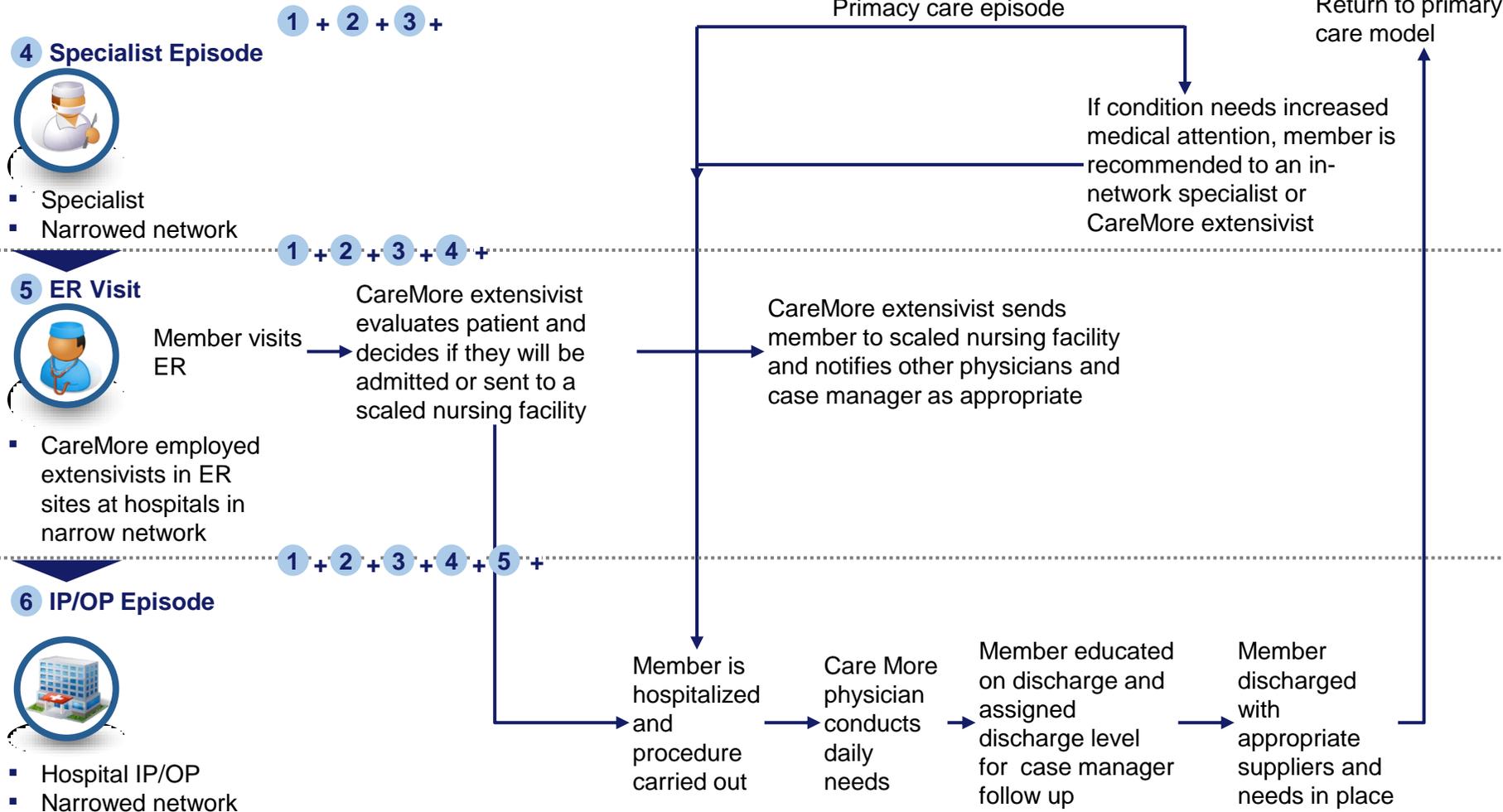


3 Physician Episode



5b There are six stages of support in a CareMore patient journey (2/2: specialized care activities)

MEMBER PROCESS DEEP DIVE



Case managers support patients throughout the journey by addressing social needs and circumstances to increase member compliance to care plan by removing social and psychological barriers to care¹

¹ For 85-90% of the population targets and scripted telephonic case management will be effective

6 CareMore addresses all of the main enablers of coordinated care



Organization and Accountability



Clinical leadership and culture development



Information sharing



Aligned incentives



Patient engagement

Summary of key elements

- Care is heavily standardized and monitored real-time
 - Clinician salaries are linked to outcomes
 - Clinicians work for CareMore and are invested in system outcomes
-
- Extensivists receive 6m+ training working with Nurse Practitioners, social services SWAT teams, home care teams and shadowing experienced extensivists in hospital and SNF ward rounds
 - Core group of experienced, highly-committed senior extensivists
-
- CareMore have developed their own in-house EMR system – QuickView – which integrates Rx, lab and utilization data to facilitate monitoring of activity, financial performance and clinical outcomes
-
- 5-65% of extensivist salary performance-related (depending on seniority) including but not limited to:
 - 30-day readmission rates
 - Compliance with discharge summary dictations
 - Outpatient clinic productivity
-
- No co-pays or deductibles
 - Free transport to all services
 - Extensive use of remote monitoring technology – e.g. twice daily BP readings for hypertension; daily weighing for CHF etc
 - Proactive engagement of families and carers

6a CareMore uses a risk-adjusted capitated payment model with individual clinician-level incentives

Overview and guiding principles

- MA risk-adjusted capitation based model - CareMore target the 40% highest-risk patients that attract the highest Medicare funding
- CareMore profits depend on providing total care at lower cost than the Medicare capitation payment

Aligning individual incentives

- Individual clinicians are rewarded for outcomes within their sphere of control: e.g. intensivists' performance bonus is linked to emergency admissions and readmissions rates

Exclusions and risk adjustments

- MA payments are adjusted using risk scoring
- Care is tiered to acuity to ensure that resources are focused on the highest risk groups

Mechanisms to mitigate volatility

- All patients are enrolled with a designated CareMore care center which is responsible for a panel of around 2,000-5,000 patients
- Overall responsibility is at the provider level (>60,000 patients)

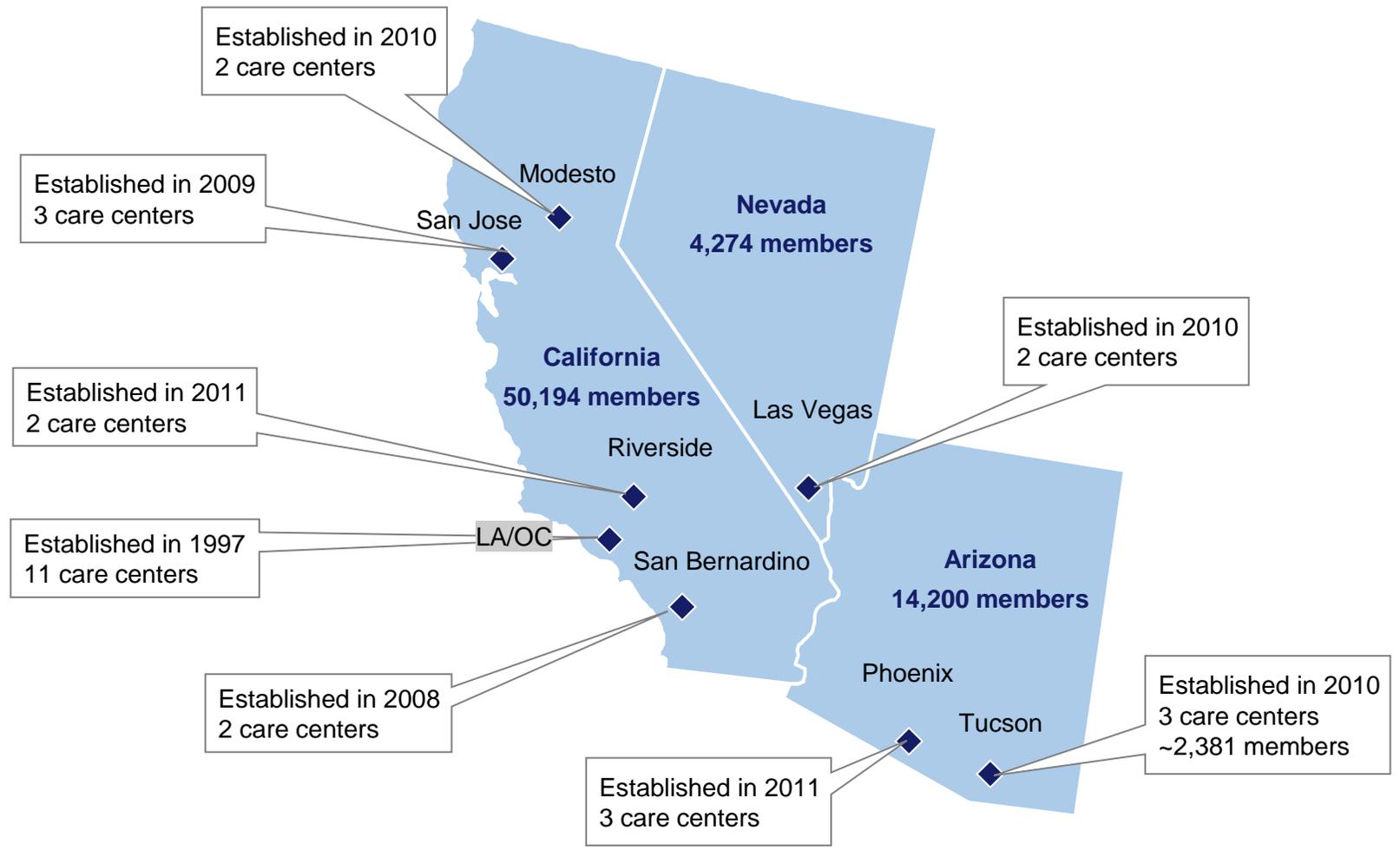
Operationalizing the payment model

- CareMore expansion is driven by the creation of the new care centers in areas with high density of MA high risk cohorts



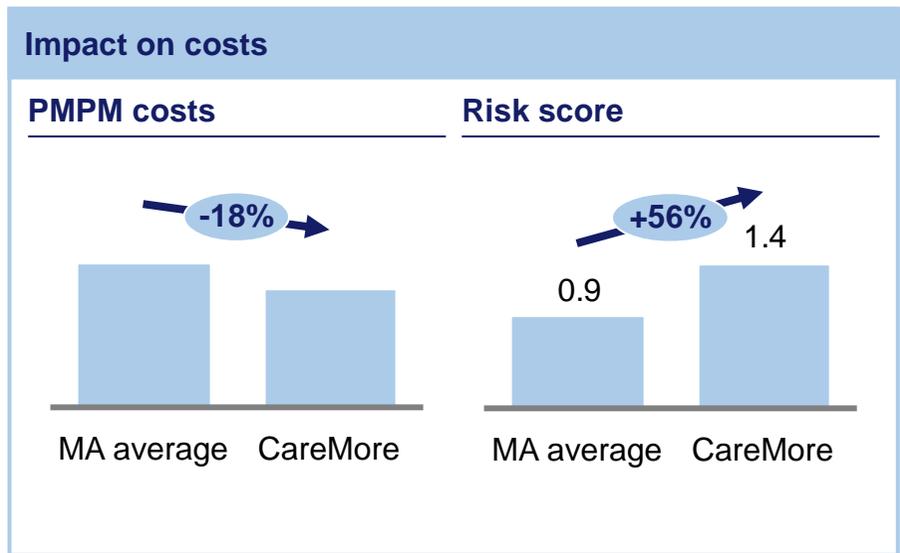
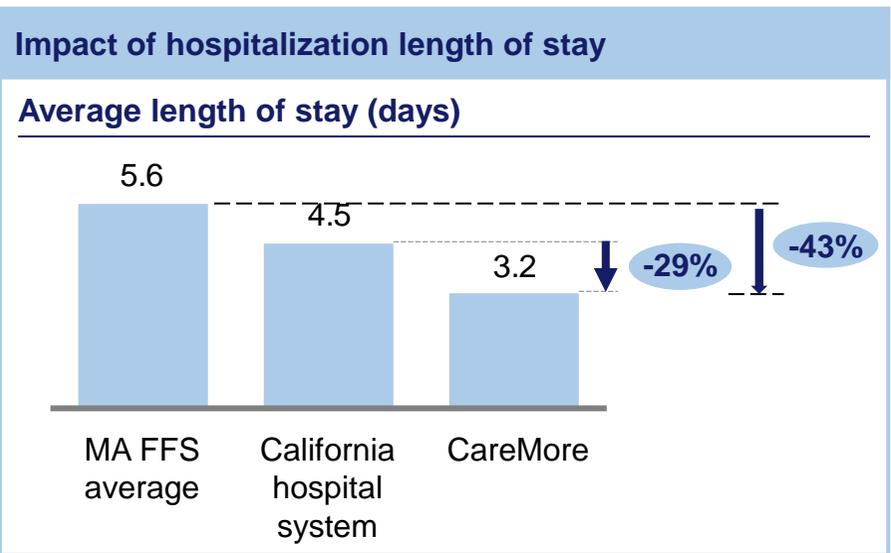
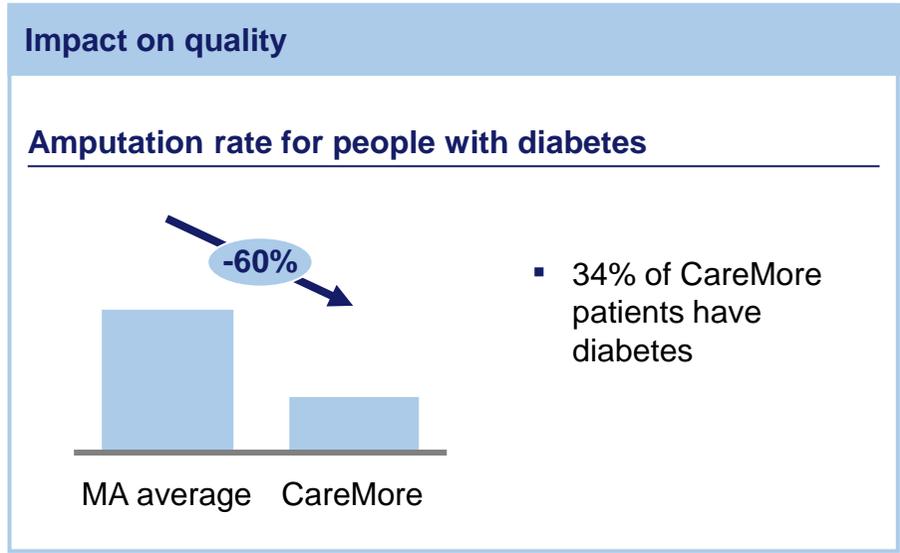
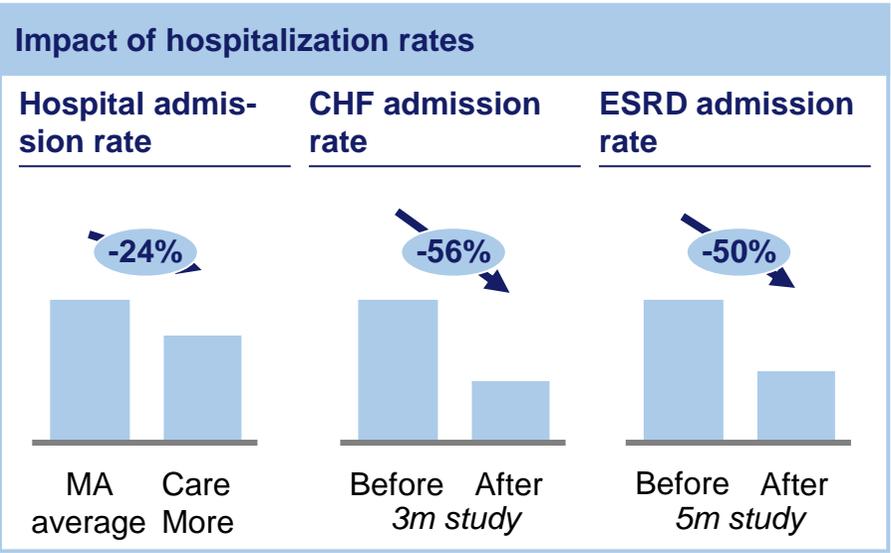
7 After starting operations in Southern California in the 1990s, CareMore has successfully deployed its care model in eight markets

PRELIMINARY



SOURCE: Management estimates for membership for the year ending 12/31/11; Alan Hoops, Morgan Stanley Townhall Meeting; Enrollment data from filings as of September 2012

8 CareMore have driven double-digit improvements in utilization, quality and costs



9 What lessons can be learnt from the CareMore model?

Do's



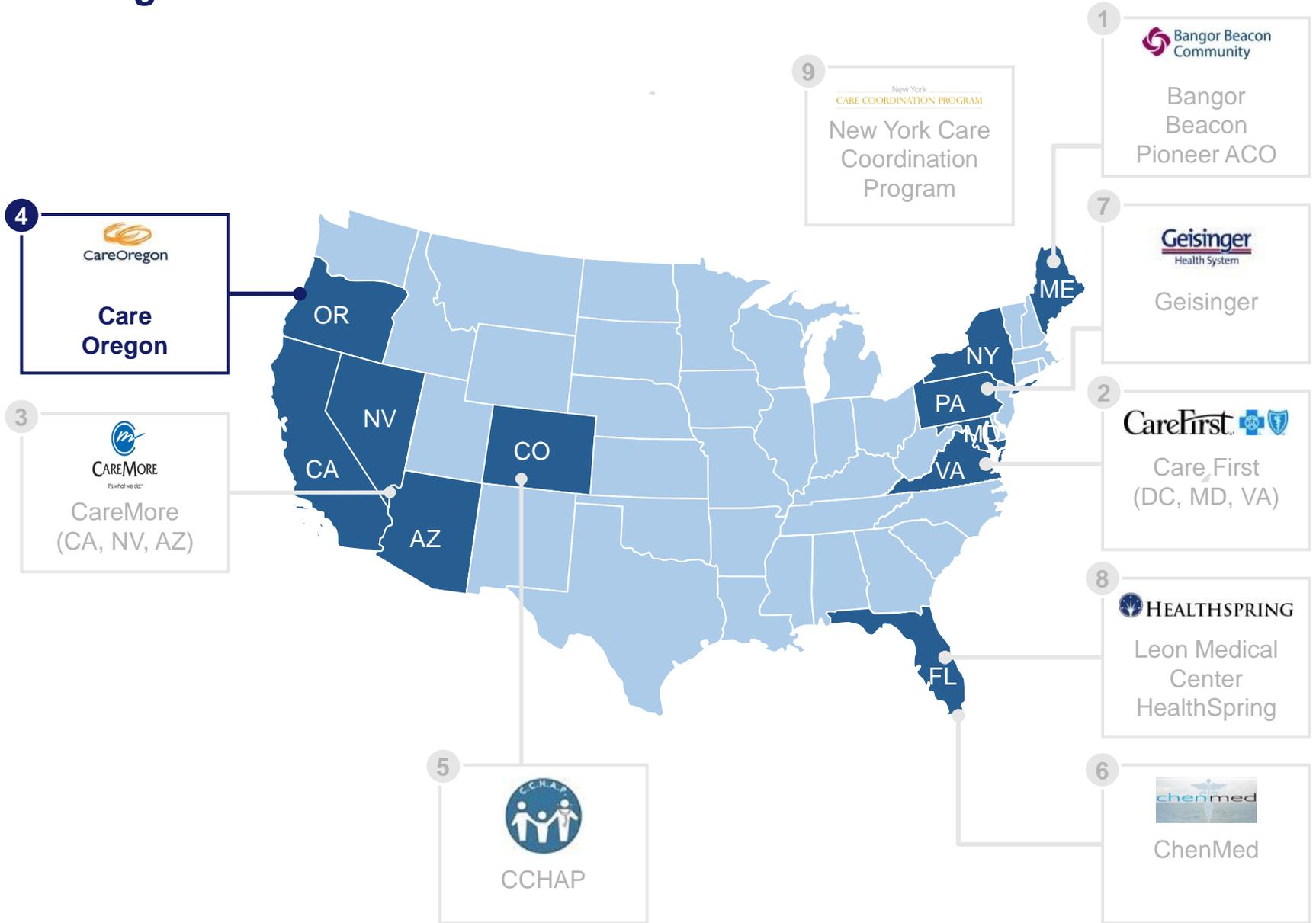
- Assign **relatively small case loads** so that clinicians can develop a deep understanding of patients' needs and circumstances:
 - **Extensivists** see ~15 patients per day – vs 40+/day for traditional hospitalist role
 - **NPs** are responsible for 100-150 patients – vs 300+ for PCP models
 - **Ambulatory care team** serves 200-500 patients
- Set performance incentives at individual clinician level
- Train new extensivists for 6m+ working with other disciplines

Dont's



- Apply this delivery model to lower cost/risk/complexity patient cohorts as it's unlikely to be efficient
- Focus training on clinical specialization – it's more important to **train in the culture of coordinated care**
- Allow case loads to become too large as this will risk clinician burn-out

CareOregon



CareOregon Care Support and Primary Care Renewal programs

Why was a change in care delivery considered?

- In 2003, CareOregon was on the verge of bankruptcy and delivering lower quartile quality performance to patients
- Two programs were developed to reward providers for continuity and quality of care:
 - **CareSupport** provides tiered, centralized case management for high risk groups
 - **Primary Care Renewal** provides a PCP-centered delivery model for the general population

What was the scope of the care model?

- Non-profit, payer-led PCMH model covering >45,000 Medicaid enrollees
- CareSupport high-intensity care coordination targeted at 3% of members responsible for 29% of spend:
 - ~750 members with highest needs
 - ~3,000 members with 2nd level needs

What were the changes made?

- Care delivered by multi-disciplinary teams
- Staff supported to operate at top of license
- Focus on population health and prevention
- Integrated behavioral health
- Barrier-free access for patients
- Patient involvement in care decisions, program design and evaluation

How was the care model put in place?

- Primary Care Renewal was pioneered by 5 pilot sites focusing on specific sub-populations:
 - Migrant labor
 - Homeless
 - People with HIV
 - Urban, ethnically-diverse populations
- CareSupport is a centralized team operating out of Portland providing care to the highest risk tier

How did payment reform support care model?

- CareSupport is funded through an annual program budget of \$2m which funds staff and operational costs
- Primary Care Renewal initially funded through a \$1.5m/year CSSI grant
- PCMHs are rewarded for:
 - Participation
 - Quality metrics
 - Reduced utilization

What was the impact in terms of quality and costs?

- CareSupport has reduced PMPM costs by 21% per year
- PMPM DE costs at Primary Care Renewal sites fell by 5% per year compared to 1% annual increase for control sites
- Across Primary Care Renewal sites there was 7.6% increase in diabetic patients with HbA1c <8; 3.4% increase in cervical screening; 12.2% increase in uptake of pediatric immunizations; 3-fold increase in the % of patients screened for depression

SOURCE: CareOregon: Transforming the role of a Medicaid health plan from payer to partner, Commonwealth Fund, 1423(5), 2010

1 The catalyst for changes in care delivery

What was the overall context? Why was this initiated?

- CareOregon membership rose in the late 1990s as managed care plans left the Medicaid market due to dwindling profits but community-based providers were unwilling to care for large numbers of Medicaid patients as reimbursement rates fell up to 45% below commercial health plans
- High prevalence of complex morbidities in adult members:
 - >60% suffer from a chronic condition, including diabetes, CHF, depression
 - ~30% suffer from >3 chronic conditions often exacerbated by psychosocial difficulties and language barriers
 - 8% make ≥4 visits to the ED per year

Who was involved in initiating the change?

- CareOregon's board revised the mission statement to make 'high quality' a core objective
- Executive team – CEO David Ford and Medical Director David Labby – realized “that we needed to move from simply paying claims to looking at improving population health as not only a health strategy, but as a business strategy.” (Labby)

How were people brought together? What circumstances helped facilitate that?

- CareOregon organized a trip for 30 stakeholders to visit the Southcentral Foundation in 2006 to view PCMH care in practice: “The whole point of taking people to Alaska was to get people fired up, to get the leadership really engaged, and to create a vision ... You have to have some sort of an engagement strategy for the people you're working with so that you can create some sort of collective will for transformation. Transformation is not something that you can mandate.” (Labby)



2 CareOregon is focused on low-income Medicaid populations and safety-net providers

	Description
Size of population targeted	<ul style="list-style-type: none"> ~128,000 Medicaid members – approximately 30% of Oregon Medicaid enrollees – 45,000 of which are enrolled in Primary Care Renewal program 67% are children 14% of adults are Dual Eligible of which over half are aged <65 years
Spend targeted	<ul style="list-style-type: none"> Payer-led program focused on total costs of care
Patient segments & pathways	<ul style="list-style-type: none"> CareSupport is targeted at the highest risk groups whatever their needs and is deliberately not disease-specific. Examples of high-risk patients include: <ul style="list-style-type: none"> Homeless with serious medical illness or substance abuse Pregnant mothers on methadone Dual Eligibles with complex social and health conditions
Providers involved	<ul style="list-style-type: none"> Care Support operates as one centralized delivery team Primary Care Renewal is offered by 16 primary care providers, many of them contracted safety-net providers. On average, CareOregon members make up 40-50% of each clinic's patient population allowing the payer to reach a large proportion of its members while only working with a limited number of providers
Payers involved	<ul style="list-style-type: none"> Medicaid Medicare/Medicaid Dual Eligibles – enrolled in Medicare Advantage Special Needs Plan Expanding to cover uninsured populations through safety net providers

SOURCE: CareOregon: Transforming the role of a Medicaid health plan from payer to partner, Commonwealth Fund, 1423(5), 2010

3 What were the goals of the new care delivery model?

Description

Patients

- To deliver continuity of care and high quality preventive medicine and chronic disease management to the most deprived population groups

Quality

- To improve quality from lower quartile to 'high quality' performance through a program of incentives

Costs

- To manage the costs of the highest-risk cohort more effectively

Physicians

- To provide support to primary care providers for the most complex and highest-need patients through the Care Support team
- To reward primary care providers for improvements to population health
- Efforts made to ensure that all members of the care team are operating to the top of their license and to distribute tasks so that people "can do what they do best"¹

System working

- PCMH teams are convened for collaborative learning sessions covering:
 - Process improvement techniques
 - Workflow analysis
 - Project management
- The CareSupport team works across PCMH practices providing intensive care for the highest risk patients
- Behavioral health is integrated as far as possible (limited by Medicaid carve-out programs)

¹ Amit Shah, Medical Director of Multnomah County Health Department (and CareOregon PCMH provider)

SOURCE: CareOregon: Transforming the role of a Medicaid health plan from payer to partner, Commonwealth Fund, 1423(5), 2010

4a CareOregon's CareSupport delivery model

Program goals and objectives

- To identify high needs / high risk populations with modifiable risk factors:
 - At risk of or experiencing a functional health decline because of lack of support or self-management
 - Using health system ineffectively or inappropriately
 - Experiencing a major health-related transition in life
- To support these groups with centralized care mgmt and coordination of services to improve quality of life and reduce costs
 - Emphasis on leveraging community resources and policies

Payment model

- Annual program budget of \$2m not including cost of care provided
- CareOregon health plan pays for CareSupport staff and program
- Provider payment model tied to performance measures that are co-developed each year
- CareOregon's CareSupport and Systems Innovation grant program
 - Has granted awarded ~16M to projects across 48 hospitals, systems, PCP and specialty clinics

Care delivery model

- **Primary care:** Clinician
- **Care team:**
 - Case manager (RN), health guide¹, social worker (BH manager)
 - Assigned to dedicated panels of patients based on PCP
 - Consulting clinical pharmacist
 - Specialized teams for transitional care, emergency post-partum, NICU
- **Responsibilities:**
 - Facilitates communication / understanding between patient and providers
 - Identify barriers to self-care
 - Locate community resources
 - Assist with complex mental/social issues
- **Interaction:**
 - Shares info with providers through telephone, email, fax
 - Join PCP in team mtgs to discuss specific patient needs
 - Most patient-team contacts by phone (10% in person onsite)
- **Management**
 - MCO-run program from centralized office
 - Concurrent Medicare / Medicaid review process

¹ Paraprofessional supervised by clinician

4a CareOregon's Primary Care Renewal program

Program goals and objectives

- Pilot a patient-centric primary care model for CareOregon's Medicaid enrollees that focuses on:
 - Population health
 - Ongoing engagement between patient and providers
 - Team-based care model to drive innovation and system-wide strategies
- Model blueprint based upon Southcentral Foundation's system in Anchorage, Alaska
- ~6K enrollees

Payment model

- Initial 6-clinic pilot funded through 1.3-1.5m/year CSSI grant program
- Three-tiered provider payment system
 - Tier 1 payments for participation in learning collaboratives, workgroups and reporting data
 - Tier 2 for hitting key metrics (access to care, HEDIS) (+tier 1 conditions)
 - Tier 3 payments for decreased acute admits, ED visits and achieving HEDIS benchmarks at 90% percentile
- Average clinic payment: \$5-10 PMPM
- Tier 3 clinic: 15% increase in primary care PMPM

Care delivery model

- **Primary care:** Clinician
- **Care team:**
 - PCP, medical assistant, care manager, BH practitioner, team assistant (admin)
 - Assigned to dedicated panels of patients
 - Consulting clinical pharmacist
 - Specialized teams for transitional care, emergency post-partum, NICU
- **Responsibilities:**
 - Schedule scrubbing
 - "Top of their credential" responsibilities
- **Interaction:**
 - Morning and afternoon "team huddles"
 - CareOregon sends PCP sites patient reports on hospital discharges
- **Management**
 - MCO-run program from centralized office

1 Paraprofessional supervised by clinician

5 CareOregon CareSupport – Care coordination processes

CareSupport process

Patient ID/enrollment	Initial assessment	Care plan	Monitor/outreach	Ongoing care
<ul style="list-style-type: none"> Identify targets by: <ul style="list-style-type: none"> predictive modeling based on claims data¹ Referrals from providers, case workers Fill in data gaps from health assessments, ED records, DME authorizations 	<ul style="list-style-type: none"> Initial assessment <ul style="list-style-type: none"> 2 FTEs spend 2 hrs/week each on assessments Standardized assessment questionnaire has reduced cost and time by 2/3 High-risk patients are evaluated via MacColl Institute's Chronic Care Model² If risk factors are "modifiable", member assigned to CareSupport team 	<ul style="list-style-type: none"> Develop personalized care plan that defines: <ul style="list-style-type: none"> modifiable and non-modifiable risk factors member's interpersonal strengths challenges / recommendations action task list for care team staff 	<ul style="list-style-type: none"> Notify and follow-up on patient appts Motivational coaching to build patient confidence Coordinate community services Specialized teams for care transitions, other high-risk episodes 	<ul style="list-style-type: none"> Strengthen care team-patient relationship Continue patient self-development and SM skills Update plans as risk change 

Technology integration

- EPIC for patient data, but currently examining IT structures to support care coordination
- Aligned Medicare / Medicaid claims tracking and processing

¹ Johns Hopkins Ambulatory Care Groups case-mix system

² Helps distinguish barriers to medical stability, medical home relationship, medical service access, SM capability, social support

6 How were key success factors addressed?



Organization and Accountability



Clinical leadership and culture development



Information sharing



Aligned incentives



Patient engagement

Summary of key elements

- CareSupport program is directly and separately funded by the payer
- Outcomes at PCMH sites and monitored for quality and financial performance
- Payer convenes PCMH sites for knowledge sharing and training
- Initial training provided for 50-60 nurses and social workers in case management and coordinated care delivery
- Multiple data sources feed predictive algorithm to identify at risk cases
- Clinical dashboards monitor utilization and quality at patient level
- PCMH providers are rewarded at three levels amounting to 15% premium if all levels are met:
 - 1. Participation
 - 2. Quality improvement
 - 3. Utilization and highest quality scores
- CareSupport team uses motivational coaching to help patients define goals and build confidence and to empower patients to assess and address their own needs

6 How did the payment model align incentives?

Overview and guiding principles

Relevant questions

- CareSupport intensive coordinated care program is funded directly by the payer
- PCMH providers receive staggered incentives for engagement, quality improvement and financial management
- All patients are Medicaid or Dual Eligibles

Aligning individual incentives

- PCMH providers can design their own internal, incentive systems

Exclusions and risk adjustments

- No exclusions as the program targets the highest risk populations

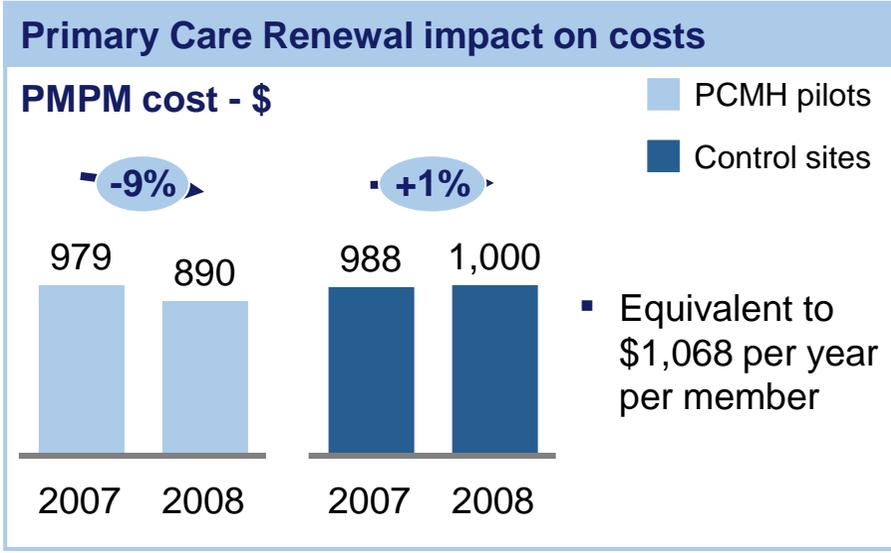
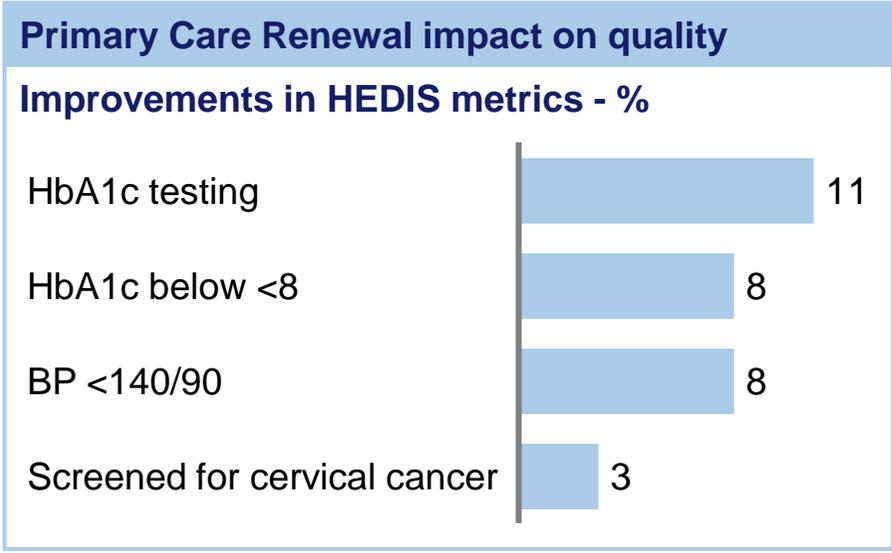
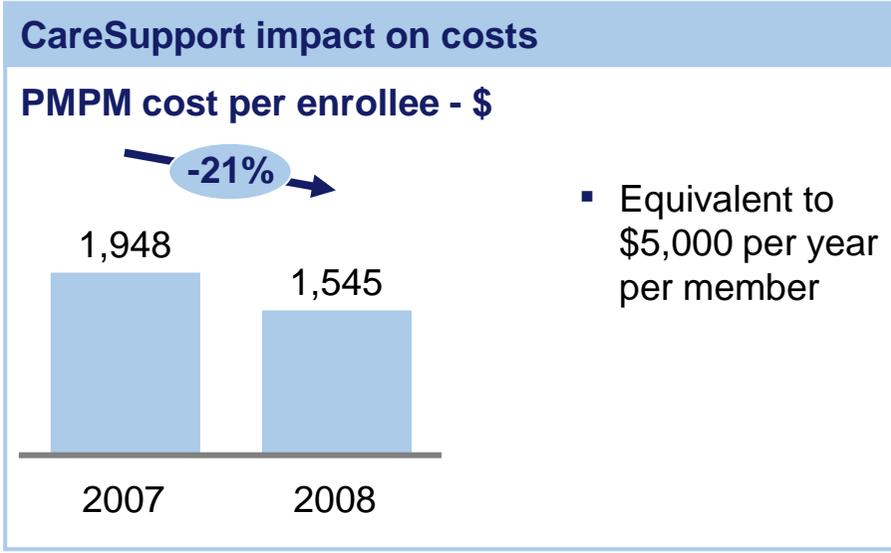
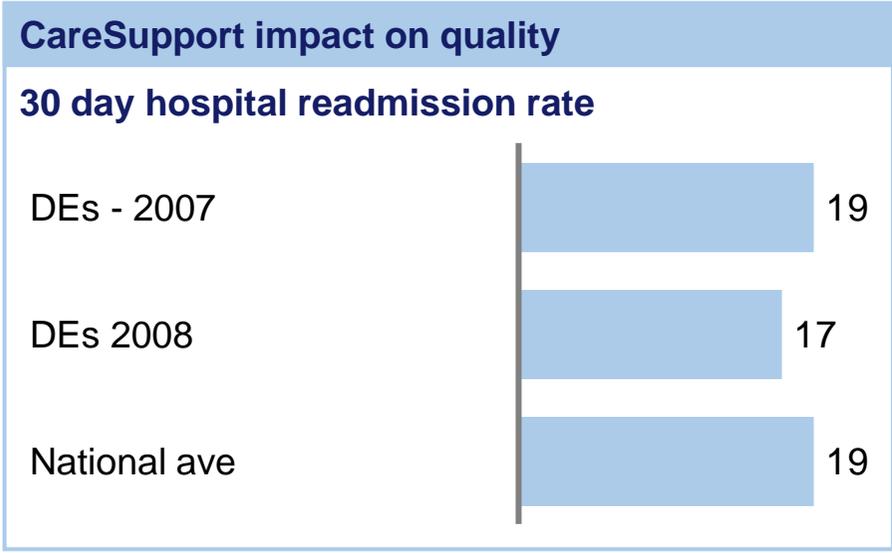
Mechanisms to mitigate volatility

- There is no minimum panel size though CareOregon members tend to be concentrated at a relatively small number of primary care providers (usually comprising 40-50% of the providers' patient population) which creates scale

Operationalizing the payment model

- CareOregon is one of the largest Medicaid insurers in the state

8 CareOregon's appear to reduce costs while driving some improvements in quality



SOURCE: Commonwealth Foundation Case Study, CareOregon, Transforming the Role of a Medicaid Health Plan from Payer to Partner, 2010

9 What lessons can be learnt from the CareOregon model?

Positives



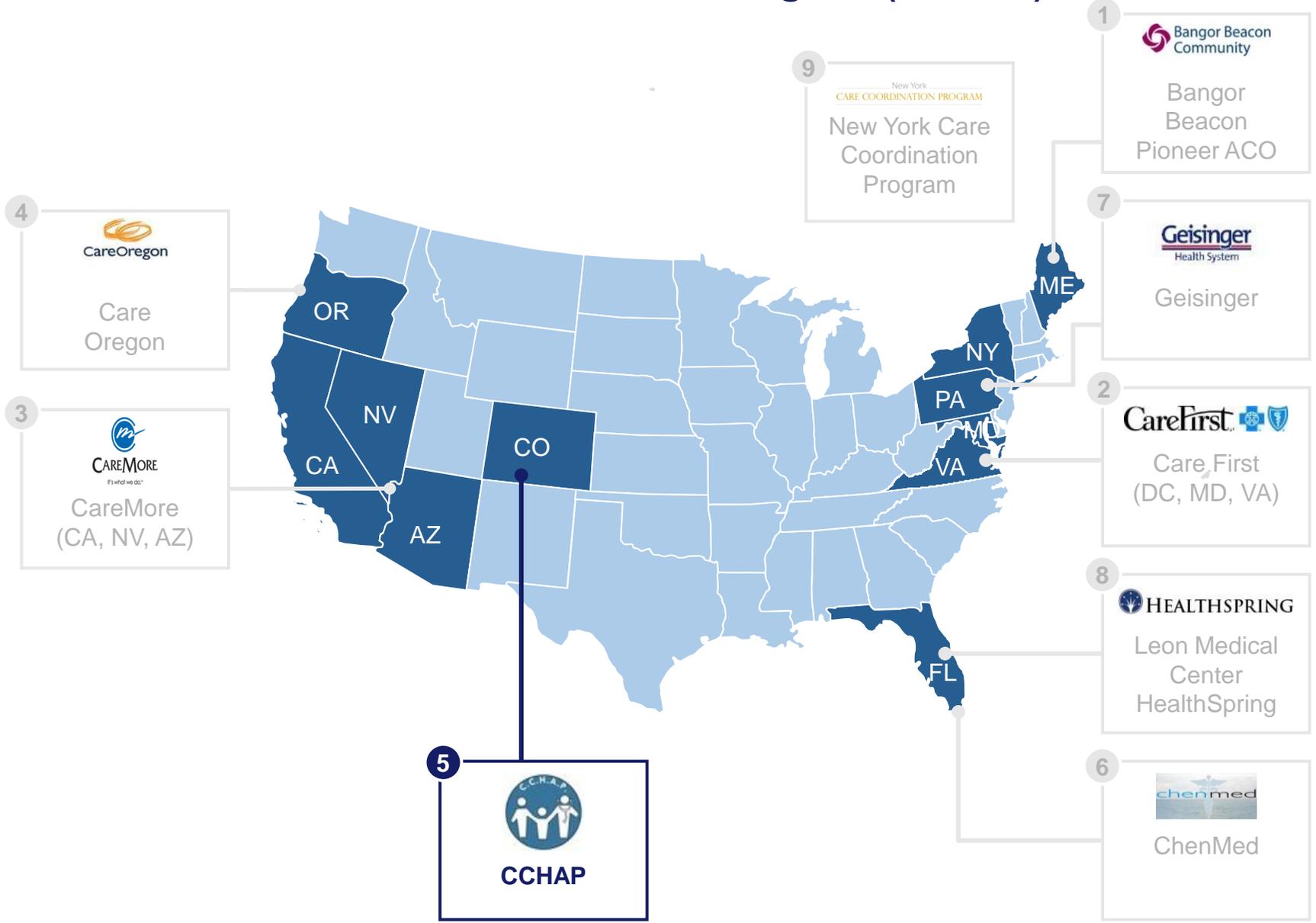
- Incorporate paraprofessionals into care teams – particularly **Health Guides** which can support patients to navigate the health system and community resources
- Provide primary care workforce with **training in behavior modification techniques**
- Incorporate data from multiple sources into risk prediction algorithms and verify with in person assessments by experienced clinicians
- Invest in creating a common vision for improving primary care delivery

Challenges



- It has not yet been possible to create and implement a system-wide EMR across such a diverse range of providers
- Medicaid carve-out arrangements make it difficult to fully integrate behavioral health services within the PCMH model unless providers are accredited, designated mental health providers in their locality

Colorado Children's Healthcare Access Program (CCHAP)



Overview: Colorado Children's Healthcare Access Program (CCHAP)

Why was a change in care delivery considered?

- The initiative was led by Colorado state government working with Denver Health, pediatric practices and other stakeholders
- The goal of the program is to maximize the number of Medicaid-eligible children in Colorado connected to a medical home
- CCHAP is a nonprofit org that began as a 18-month pilot in the Denver area that has expanded across CO to assist pediatric practices with gaining higher Medicaid reimbursement rates for 1.2m Medicaid children, of which 150,000 enrolled so far

What was the scope of the care model?

- Children from low income families (Medicaid-eligible) in Denver and surrounding rural areas
- Has expanded to include pre-natal care for pregnant women
- Covers 93% of CO's private pediatric practices, or 116 practices with 405 providers serving 1.2 million children, plus 47 family practices

What were the changes made?

- Eligible families are provided with care coordination and other support services
- Clinical practice staff receive training and are linked to community-based resources including BH, housing, social services, housing and nutrition

How was the care model put in place?

- A small CCHAP care coordination team manage referrals, conduct assessments and support practices
- Initially implemented in Denver and surrounding rural areas, has since been adopted in Kent County, Michigan
- The program launched in 2007 and was fully operational within 2 years

How did payment reform support care model?

- Pediatric and family practices are assisted to become certified for higher rates of Medicaid medical home reimbursement for preventive services
- CCHAP is funded through multiple foundations
- Enhanced reimbursement to CCHAP practices is financed through CO's existing Medicaid EPSDT program

What was the impact in terms of quality and costs?

- Children in CCHAP practices (compared to non-CCHAP practices) have 5-21% lower ED utilization; 32% increase in share of patients receiving preventive care visits; 23-33% lower costs to the state Medicaid program
- High levels of physician and family satisfaction (97% would recommend the program)

SOURCE: Commonwealth Foundation Case Study, Colorado Children's Healthcare Access Program:

Helping Pediatric Practices Become Medical Homes for Low-Income Children, 2010

PROPRIETARY AND CONFIDENTIAL || PRE-DECISIONAL

1 CCHAP was introduced to increase the proportion of low income children in Colorado with access to a medical home

What was the overall context? Why was this initiated?

- In 2007, CO passed a state mandate that required Medicaid agencies to maximize the number of children with a medical home (MH) – many of whom had been shifted to FFS in 1997
- CCHAP is a nonprofit org that began as a 18-month pilot in the Denver area that has expanded across CO to assist pediatric practices with coordinating care and Medicaid enrollment and reimbursement for over 1.2M Medicaid children (150K placed in medical homes)

Who was involved in initiating the change?

- Colorado state government, Denver Health (integrated network of FQHCs/CHCs), pediatric practices, University of CO-Denver School of Medicine, The Children's Hospital, community organizations, Family Voices and the Department of Health Care Policy and Financing (HCPF)
- A well-known and respected physician in the pediatric community – Dr. Steve Poole – led the initiative and this was critical in getting private pediatric practices on board

How were people brought together? What circumstances helped facilitate that?

- In 2003, Colorado participated in the National Medical Home Learning Collaborative, to improve the quality of care for children with special health care needs, and from this built a cadre of committed practices with experience of, and commitment to, the medical home concept
- In 2007, the group went out to private pediatric practices to understand the barriers that prevented 80% from enrolling Medicaid-eligible children and designed the CCHAP program around what they learnt

SOURCE: Commonwealth Foundation Case Study, Colorado Children's Healthcare Access Program: Helping Pediatric Practices Become Medical Homes for Low-Income Children, 2010

PROPRIETARY AND CONFIDENTIAL || PRE-DECISIONAL



2 CCHAP targets the 1.2 million Medicaid-eligible children in the state

	Description
Size of population targeted	<ul style="list-style-type: none">1.2 million Medicaid-eligible children in Colorado:<ul style="list-style-type: none">>65% belong to a racial or ethnic minority population>30% belong to a different culture to their primary health provider
Spend targeted	<ul style="list-style-type: none">Total costs of care
Patient segments & pathways	<ul style="list-style-type: none">Pediatric carePre-natal maternity care
Providers involved	<ul style="list-style-type: none">>30% of federally qualified health centers (FQHCs) in CO230 sites and 750 providers – accounting for 95% of the state's private pediatric practice + 47 family practicesOver 30 community orgs
Payers involved	<ul style="list-style-type: none">CCHAP negotiates with Medicaid for higher rates of reimbursement for affiliated practices achieving process and quality targetsMultiple philanthropic foundations support the additional costs of the CCHAP program
Broader network	<ul style="list-style-type: none">University of Colorado Denver School of Medicine and Children's Hospital donate office space, computers and IT support

SOURCE: Commonwealth Foundation Case Study, Colorado Children's Healthcare Access Program:

Helping Pediatric Practices Become Medical Homes for Low-Income Children, 2010

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3 CCHAP aims to improve preventative care and access to support

Description

Patients

- To improve access, quality, continuity and coordination of care for children of low income families

Quality and costs

- To reduce costs of care overall while delivering improvements in experience and outcomes by addressing disparities in outcomes for uninsured/publicly-insured children:
 - Higher rates of hospital admissions
 - Higher rates of mortality and severity of illness
 - Higher probability of being admitted to the hospital through the emergency room
 - Higher hospital costs

Physicians

To address the barriers that prevent private providers from enrolling Medicaid-eligible children and their families:

- Poor reimbursement
- Difficulties with eligibility and enrollment
- Problems with claims processing
- Need for social service support for families
- Poor access to and coordination of mental health services
- Need for better case management and care coordination
- Trouble getting children in for regular preventative care, including immunizations
- Transportation problems in low-income families
- Need to learn more about culturally sensitive and responsive care
- Difficulty in obtaining and affording interpreters for health care visits
- Need for help in identifying all the resources for which children are eligible

SOURCE: Commonwealth Foundation Case Study, Colorado Children's Healthcare Access Program:

Helping Pediatric Practices Become Medical Homes for Low-Income Children, 2010

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4 CCHAP care delivery processes

Care delivery model

- **Primary care:** Pediatric or family practice PCP
- **Care team:**
 - 2 CCHAP care coordinators (CC) to manage referrals, Medical Director on consult, administrator (local nurses and EPSDT worker as needed)
 - Update / coordinate with PCP
- **Performance mgmt**
 - MOU with community orgs for long-term commitment to support CCHAP practices
 - Ongoing information updates, training and technical assistance for providers and practices
- **Payment model**
 - Enhanced provider rates for CCHAP practices that offers medical home services¹
 - Enhanced payments by child age: < 2 (\$10 PMPM); <3 yrs (\$40 PMPM); raising it to
 - Annual CCHAP funding is ~500K (through 8 foundations), along with in-kind donations

Care coordination process

Patient ID/enrollment	Initial assessment	Care plan	Monitor/outreach	Ongoing care
<ul style="list-style-type: none"> ▪ When child is in need of support services, practice obtains family consent and refers patient to 1 of 2 CCHAP care coordinators ▪ Assists with Medicaid enrollment and eligibility issues 	<ul style="list-style-type: none"> ▪ CC contacts family within 24 hours to discuss referral reasons and conduct basic assessment (~60 /month) ▪ CC follows up with PCP within 48 hours of family contact to update referral status (most resolved within 1 week) ▪ If county EPSDT2 outreach worker has capacity, CCHAP may connect family to outreach worker for services 	<ul style="list-style-type: none"> ▪ CC coordinates necessary mental health and social services (e.g., developmental / behavioral, housing, nutrition, cultural, family support) ▪ If support services are not readily available in local area, CCHAP arranges for services from other parts of the state 	<ul style="list-style-type: none"> ▪ CCHAP provides practice with weekly updates and technical assistance (e.g., use of standardized screening tools, free vaccines, coordination for special needs children, and early intervention programs) ▪ Assists practices with proper Medicaid billing practices 	<ul style="list-style-type: none"> ▪ CCHAP provides additional training for community stakeholders and ideas for improving local care delivery ▪ Assists with developing and implementing network-wide wellness initiatives ▪ Assists with analytics (e.g., analyze state claims data vs. encounter data, submit reports to state) ▪ Provider resource helpline 

Technology integration

- Limited technology integration and enablement of services
- CCHAP administration, support services and other activities are automated in-house
- Working with state immunization registry to integrate database with automated reminder system that leaves voice or SMS on parents' cell phone to remind them of appts

1 Performs prerevisit planning and post-visit outreach / follow-up 2 Cost and utilization incentive benchmarks "owned" by the entire delivery system (lump sum payment from health plan) 3 E.g., monitor blood pressure supplemented by pharmacist-led case mgmt

SOURCE: Commonwealth Foundation Case Study, Colorado Children's Healthcare Access Program:

Helping Pediatric Practices Become Medical Homes for Low-Income Children, 2010

5 Range of practice support services offered by CCHAP

Medical home administration

- Enhanced provider reimbursement including premiums for preventive care services for practices that provide a medical home to child Medicaid beneficiaries
- Enrollee and eligibility assistance
- Business systems review to improve claims processing, coding and denials
- Practice administrators network connects practice managers and provides a forum for knowledge and information sharing, and peer support

Primary care delivery

- Cross-cultural communications training for practices that request it
- Provider resource hotline for children with special health needs
- Connecting practices with free services for selecting and obtaining screening tools and training
- Assisting practices to use the Medicaid medical home index to assess their ability to provide medical home component services
- Technical assistance to enable practices to develop continuous improve programs

Linking to other services

- Mental health, social services and behavioral health services
- Assuring Better Child Health and Development – promoting standardized developmental screening tools
- Early Periodic Screening, Diagnosis and Treatment program – federal program
- Colorado Medical Home Initiative – state-wide collaborative
- Vaccines for Children Program - federal program providing free vaccines
- Health Care Program for Children with Special Needs – state program that provides care coordination for children with special needs
- Early Intervention - national program for infants and toddlers at risk of developmental delays or disorders

SOURCE: Commonwealth Foundation Case Study, Colorado Children's Healthcare Access Program: Helping Pediatric Practices Become Medical Homes for Low-Income Children, 2010

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6 CCHAPs use of care coordination enablers



Organization and Accountability



Clinical leadership and culture development



Information sharing



Aligned incentives



Patient engagement

Summary of key elements

- Medical home model assigns greater responsibility for care with the primary pediatric practice than the alternative FFS model
- CCHAP supports practices to achieve quality improvement targets which make them eligible for higher Medicaid reimbursement
- CCHAP is led by a well-known and well-respected senior physician who was able to convince private practices to engage
- Practices aligned to CCHAP are offered training and peer forums for knowledge sharing and peer support
- CCHAP is not a technology-driven program, but some processes are automated – e.g. immunization invites, reminders and recalls
- CCHAP provides a centralized analytics services to support practices to meet Medicaid requirements
- Technical support to optimize Medicaid billing
- Premium by age: < 2yrs (\$10 PMPM); <3 yrs (\$40 PMPM)
- In total, these incentives raise the Medicaid rates to $\geq 120\%$ of standard Medicare rates for preventive services, and rival those of some commercial HMOs in CO
- CCHAP links practices and families with community support organizations and addresses barriers to access for families: e.g. transportation, automated reminders

SOURCE: Commonwealth Foundation Case Study, Colorado Children's Healthcare Access Program:

Helping Pediatric Practices Become Medical Homes for Low-Income Children, 2010

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6 CCHAP negotiates enhanced Medicaid reimbursement rates for providers and funds care coordination for highest need patients

Overview and guiding principles

Relevant questions

- Goal of the program is to maximize the number of Medicaid-eligible children enrolled in pediatric and family practice Medical Homes rather than FFS models of primary care
- CCHAP negotiate higher reimbursement rates for participating practices and coaches them on effective billing

Aligning individual incentives

- Practices offering Medical Home services to Medicaid-eligible children receive enhanced monthly fees which vary by child age:
 - < 2yrs (\$10 PMPM)
 - <3 yrs (\$40 PMPM)

Exclusions and risk adjustments

- Practices can identify patients in need of additional support delivered (and funded) by the CCHAP coordinator team

Mechanisms to mitigate volatility

- The program encourages private pediatric/family practices to provide a medical home for a population comprising at least 10% Medicaid/CHIP-eligible children

Operationalizing the payment model

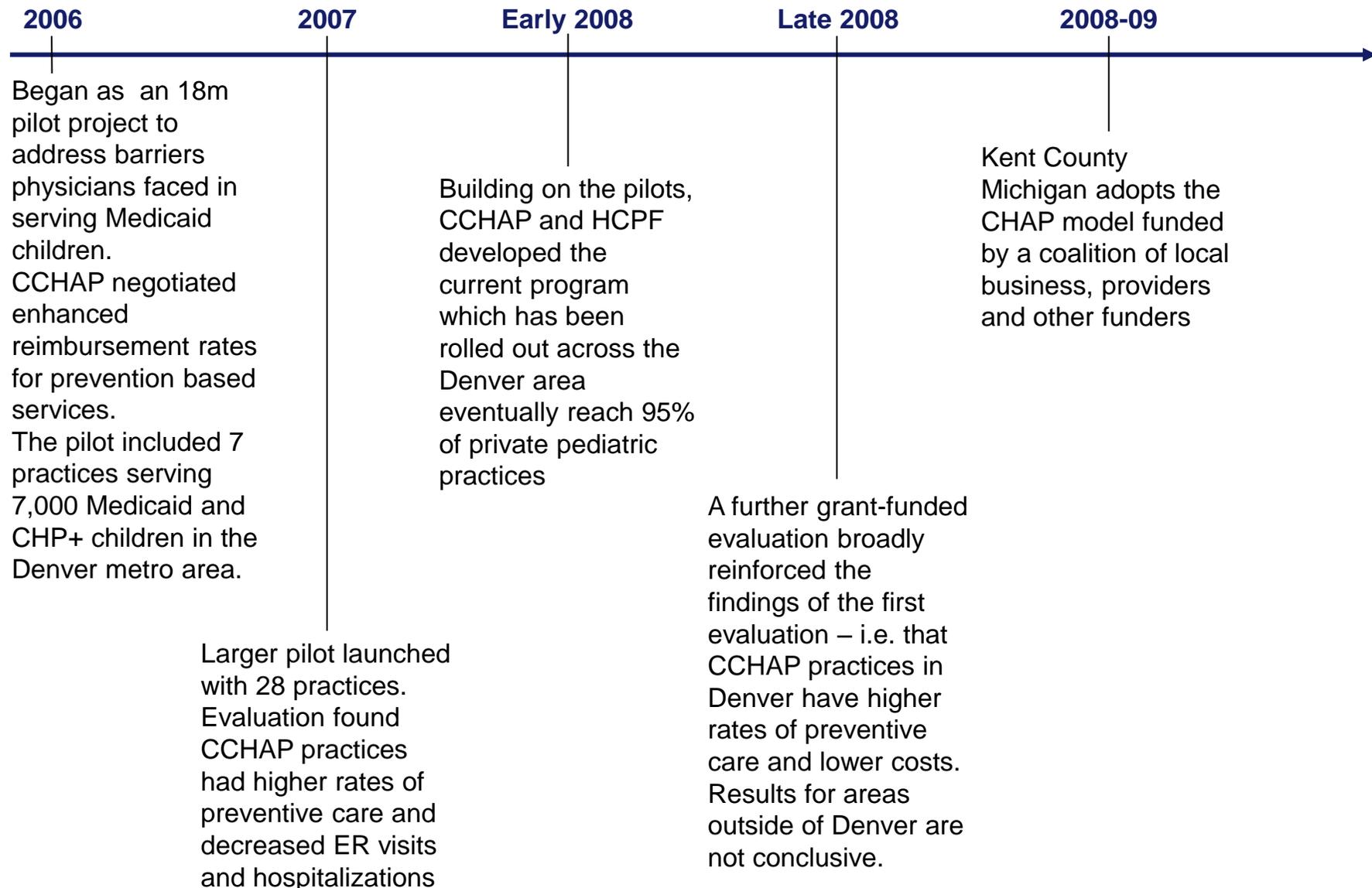
- The payment model relies primarily on maximizing income under existing Medicaid arrangements as well as providing some additional financial incentives funded by foundations (costing \$500,000 per year for a program covering 150,000 children)

SOURCE: Commonwealth Foundation Case Study, Colorado Children's Healthcare Access Program:

Helping Pediatric Practices Become Medical Homes for Low-Income Children, 2010

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7 The CCHAP program was implemented over a three year period



SOURCE: Commonwealth Foundation Case Study, Colorado Children's Healthcare Access Program: Helping Pediatric Practices Become Medical Homes for Low-Income Children, 2010

8 CCHAP practices lowered costs while improving preventive health metrics by reducing ER utilization

Impact on quality metrics

Well child visits (preventive health) - %



ER utilization - %



ER utilization (chronic conditions) - %



Impact on costs

Median reimbursement (non-ER), 2007-08, US\$



Median reimbursement (non-ER) for children with chronic conditions, 2007-08, US\$



Note: Results for Denver Metro area for all indicators except well child visits which includes Denver area and El Paso

SOURCE: Commonwealth Foundation Case Study, Colorado Children's Healthcare Access Program:

Helping Pediatric Practices Become Medical Homes for Low-Income Children, 2010

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9 What advice would you give to organizations who are designing a new care delivery model?

Lessons learned

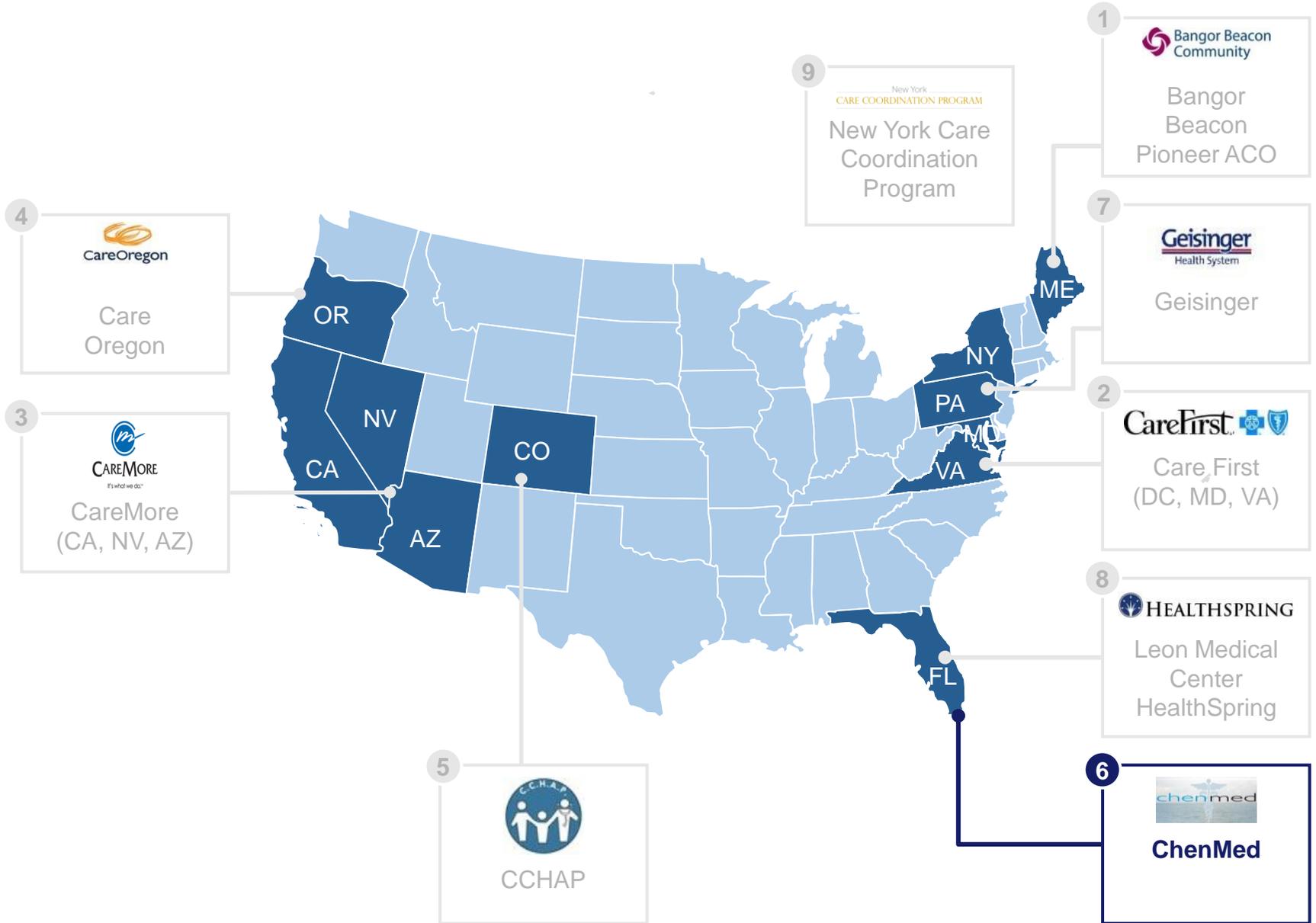


- CCHAP relies on a combination of **financial incentives, centralized support and training**, and links to resources
- Practices value care coordination help as much as financial benefits
- Many practices generate at least as much financial benefit from learning how to bill Medicaid effectively (without 'upcoding') than they gain from enhanced reimbursement rates
- **Well-known and respected clinicians in leadership positions** drive engagement and uptake

Challenges



- The Program had to address **strong negative attitudes**, experiences and myths about working with Medicaid
- Logistical challenges to scaling up the program over less densely populated areas as the program relies on a centralized support services able to deliver rapid assessments and support



Overview: ChenMed

Why was a change in care delivery considered?

- ChenMed is a family-owned private primary care provider franchise based in Florida but now operating out of multiple states in the South East acting as Medicare Advantage provider
- It was founded 25 years ago by a physician who saw an opportunity to provide better care at lower cost by focusing on proactive case management, barriers to adherence and incentives for clinicians to reduce avoidable hospitalizations

What was the scope of the care model?

- The program is aimed at low to middle income Medicare Advantage patients with complex chronic care needs
- There are currently 22 ChenMed health centers

What were the changes made?

- Patients are offered high-frequency consultations (minimum 1/month), enhanced services in a single location and free transport to appointments
- Physicians are offered small panel sizes (typically 1:400) and financial incentives to manage patient care out-of-hospital
- High staff-to-physician ratios support task-shifting

How was the care model put in place?

- The ChenMed model was developed over 20 years from a small base
- Clinician-led with strong organizational cultures and shared values
- Very strong IT infrastructure supports care delivery, performance management and revenue optimization

How did payment reform support care model?

- Full capitation model with physicians taking on an increasing proportion of risk as they build experience with the system:
 - Level I: FFS
 - Level II: Salary plus upside risk
 - Level III: Salary plus full risk
- Each physician manages ~\$7m of spend

What was the impact in terms of quality and costs?

- Compared to national averages for the population group, ChenMed reports 18% lower hospitalization rate and 17% lower readmissions rates

1 Context: ChenMed was developed by a physician who saw an efficiency opportunity in the complex elderly segment

What was the overall context? Why was this initiated?

- The ChenMed model was created by a single physician who saw an opportunity to provide higher quality and more efficient care to high-need elderly patients that other providers tended to avoid
- It has gradually expanded the franchise bringing in primary care physicians motivated by the ChenMed operational and financial model and specialists according to demand

How were people brought together

- ChenMed actively target physicians working in academia with the prospect of higher earnings, a collaborative environment and more time with patients
- Specialists are recruited when justified by patient volume and the relevance of the specialty to out-of-hospital care, priority specialties include cardiology, orthopedics, and oncology
- Specialists are initially started on a fee-for-service basis and gradually move up to partial capitation, then global capitation, then performance based salary
- ChenMed tries to recruit physicians who share their values and philosophy of hospitalization avoidance through proactive and management in primary care; they try to avoid over-utilizers



2 Scope: ChenMed operates 22 health centers in Florida and Virginia

Description

Size of population targeted

- ChenMed has franchises in Florida and Virginia and is proactively seeking organic growth through its franchise model across the South East of the USA

Spend targeted

- ChenMed focuses on the 5% of patients responsible for 40-50% of total healthcare spend
- It operates a full capitation model covering primary and acute care and medicines spend

Patient sub-groups

- ChenMed targets elderly, low-to-middle income patients with complex chronic conditions

Providers involved

- ChenMed aims to offer most services under one roof including primary care, outpatient care, diagnostics, dental care, pharmacy and complementary medicine including acupuncture
- Preferred hospitals selected on specific condition/procedure basis (e.g., one hospital for all CABGs)

Payers involved

- ChenMed works with Medicare Advantage to adjust the risk score by up to 20% based on their proprietary risk stratification algorithm

3 Goals: ChenMed aims to minimize avoidable hospital admissions through intensive primary care and aligned incentives

Description

Patient access	<ul style="list-style-type: none">▪ ChenMed offers patients regular appointments with their named PCP with the volume predetermined by the risk stratification model (minimum 1 per month)▪ Patients are offered free transport to/from the health center to encourage attendance▪ ChenMed medical centers are set up to look/feel like a quiet ER with rapid access for unscheduled appointments available to reduce patient ER utilization
Quality of care	<ul style="list-style-type: none">▪ ChenMed views every ER attendance and unplanned hospitalization as a failure to be discussed in 3-times weekly case review meetings▪ ChenMed aims to optimize patient compliance with medications and treatment guidance
Costs	<ul style="list-style-type: none">▪ Efficiency gains are implicit within the model of hospitalization avoidance
Physicians	<ul style="list-style-type: none">▪ ChenMed aims to attract physicians that share their philosophy and values who are gradually brought into the risk-sharing, capitation-based remuneration model▪ Task-shifting is used extensively with trained, but unqualified, health assistants carrying out routing clinical tasks such as BP monitoring, clinical measurements, administration
System level	<ul style="list-style-type: none">▪ ChenMed aims to deliver health system efficiencies through more appropriate, prevention-led care

4 & 5 Operational and other changes: ChenMed improves patient experience and delivery efficiency

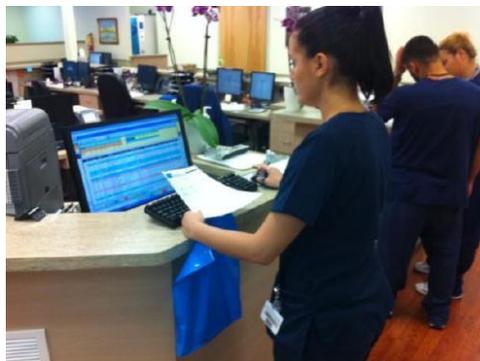
Free patient transport to/from health center



Impact

- Better follow-up and compliance
- Improved patient satisfaction
- Ensures high-risk patients are seen regularly for risk assessment

'Air traffic control' to minimize waiting times



Impact

- Staff use technology to guide patient flow
- Data collected and analyzed to determine KPIs of throughput and efficiency

Mobile access to patient records



Impact

- MDs can access patient data and respond to patient's questions or calls after office hours
- Data is encrypted and can be removed remotely in case device is lost

6 How has innovation addressed the key challenges?

Summary of key elements

Prestige and workforce issues

- ChenMed actively targets physicians working in academia
- Patients are offered high-intensity, proactive care with their own primary care physician

Investment in infrastructure/technology

- ChenMed medical centers are designed to look and operate like ERs with a central “air traffic control” station surrounded by examination rooms, with diagnostics, digital pharmacy and ancillary services on site

Clinical standards and quality improvement

- Clinical outcomes and utilization are measured and monitored and discussed in 3 times weekly clinical review meetings – once in person; twice by phone – which all physicians are required to attend

Information sharing and use of data

- ChenMed has invested heavily in proprietary, primary care-focused medical records with all clinically-irrelevant elements stripped out
- Technology is used to stratify patients and design care plans; to ensure physicians have real-time, mobile access to patient data; and to aggressively monitor performance

Misaligned financial incentives

- ChenMed operates on a full capitation basis and physicians are gradually introduced to risk-sharing and performance management eventually accounting for 40-50% of their earnings

6a Financial incentives: ChenMed brings specialists on a journey to employed full risk-sharing



Payment model

Fee for service

Limited risk

Medicare advantage focused

Global capitation

Full up- and down-side risk sharing

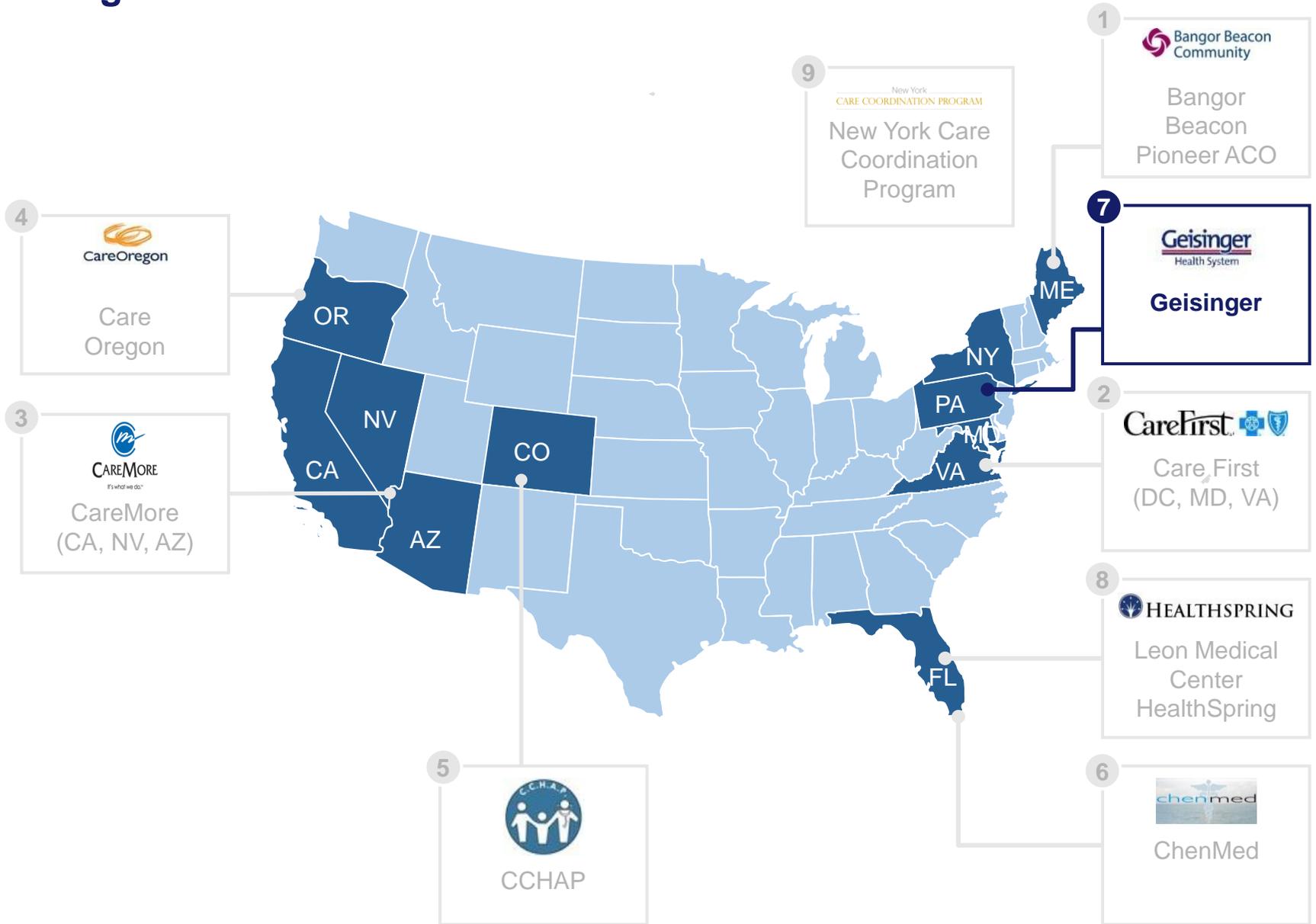
Steps in selection process

Start with a pool of high quality specialty physicians

Select for those who are "thinkers not doers" (i.e., high quality low utilizers)

Gradually augment FFS model to include upside risk sharing

Incorporate physician full-time onto Chen med staff



Overview: Geisinger

Why was a change in care delivery considered?

- Geisinger serves rural, central and NE Pennsylvania – patients are older, poorer and sicker than national averages with a high prevalence of chronic conditions and ambulatory care sensitive hospitalization rates at 3 times national averages
- The program seeks to optimize health outcomes and reduce costs by implemented a medical-home approach with intensive use of IT, incentives, patient engagement, and remote access and monitoring solutions

What was the scope of the care model?

- Geisinger is a large plan covering 2.6m people
- 60% of care delivery is delivered by non-Geisinger providers
- Geisinger has its own health insurance plan (235,000 members) but also serves Medicare, Medicare Advantage and third party plans

What were the changes made?

- Designated PCP, medical home model
- Patients have 24/7 access to care services, dedicated nurse care coordinators and a suite of tele-health tools
- Patient can access their EHR to view lab results, schedule appointments, receive reminders, and e-mail providers directly

How was the care model put in place?

- Initially implemented as a pilot scheme but later rolled out across a larger population

How did payment reform support care model?

- Physicians, non-physician staff, sites and teams are paid incentives (P4P) for performance and premiums for participating in integrated programs and/or offering enhanced (e.g. out-of-hours) services
- Best practice, episode-based payments for packages of care (e.g. CABG) and care bundles for chronic disease

What was the impact in terms of quality and costs?

- 20-25% reduction in hospitalizations; up to 50% reduction in readmissions; 7% reduction in costs for Geisinger sites compared to control group
- Compliance with best practice care process steps increased (from 59% to 86% in 3m for CABG) through protocol-defined, episode-based payments for IP care monitored using a fully integrated HER; leading to a fall in CABG-readmissions of 44%

SOURCE: Paulus RA, et al. Health Affairs 2008; Reforming the healthcare delivery system, Geisinger report , 2009

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Overview – Geisinger’s medical-home approach to chronic conditions led to reductions in hospital admissions and medical costs

1 Background

Region: Pennsylvania, U.S.

Health system: Geisinger Health System (integrated system)

The challenge

- Geisinger’s 2.6mn patients are, on average, poorer, older, and sicker than the patients nationally
- Chronic care diseases are the leading cause of death and disability in Pennsylvania, accounting for
 - 80% of state healthcare costs and hospitalizations
 - 76% of physician visits
 - 91% of filled prescriptions
- Confronted with the challenge of using innovation to optimize health outcomes and reduce costs, Geisinger implemented the medical-home approach

2 Initiative details

Approach

- Geisinger used the medical home approach to improve outcomes and cost management for patients with chronic diseases
- With the medical home, primary care is organized around the relationship between patient and personal clinician

Program description

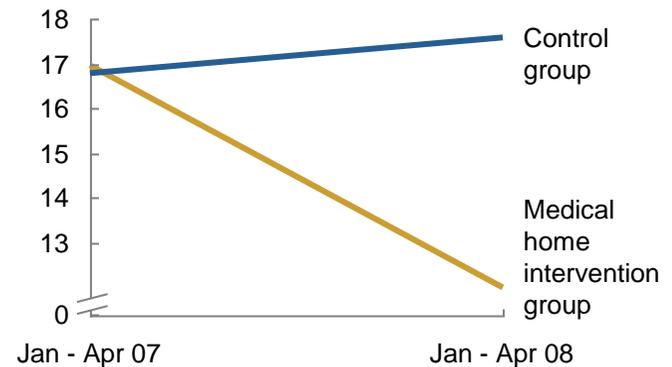
- The pilot program from two sites included
 - twenty-four-hour access to care services (enhanced through the use of nurse care coordinators, care management support, and home-based monitoring)
 - patient access to electronic health records (EHRs), allowing patients to view lab results, schedule appointments, receive reminders, and e-mail providers
- Practice-based payments to compensate for extra work and additional staff
- Performance reports to monitor results

3 Impact

Productivity

- Twenty percent reduction in hospital admissions
- Seven percent savings in medical costs
- Based on this success, Geisinger is expanding the initiative to ten additional practice sites and one non-Geisinger practice

Readmission rates in phase two of pilot



Time to impact

1-2 years

4 Key success factors

- Align incentives with physicians in care settings and from different health systems
- Apply EHR platform to ensure knowledge transfer throughout the system, and to those who know how to use and maintain it

5 Who could implement this initiative?

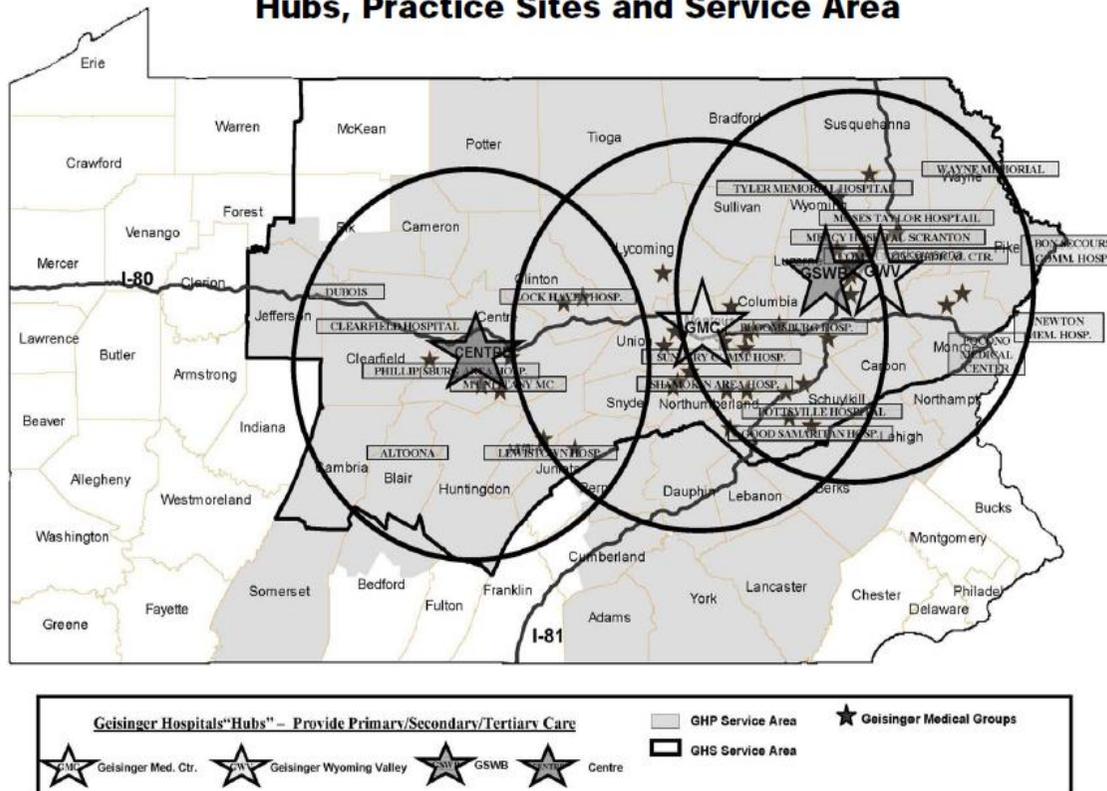
- A payer/system that pays for care, provider, or integrated system
- An organization that has convening power and can leverage scale across providers

1 Context: Geisinger Health System uses an open integrated model to serve patients in rural Pennsylvania

Geisinger Health System

- Located in central and northeastern Pennsylvania
- 235,000-member health plan
- Serves a population of 2.5mn
- 700 employed physicians in 55 clinical-practice sites
 - Subset of physicians are active in 17 non-Geisinger hospitals
- Three acute care hospitals, specialty hospitals, and ambulatory surgery campuses
- 60% of care delivery is provided by non-Geisinger physicians

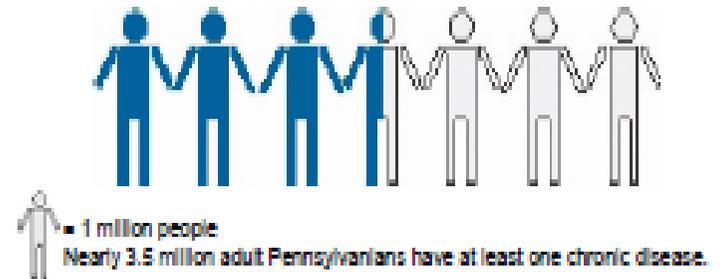
**Geisinger Health System
Hubs, Practice Sites and Service Area**



2 Scope: Chronic disease is a serious challenge in Pennsylvania, contributing to more than 40,000 avoidable hospitalizations per year

- Pennsylvania's admission rates for chronic heart disease are nearly three times higher than the national average of 612 per 100,000
 - This accounts for 15,000 avoidable hospitalizations annually
- Admission rates for asthma are three times than those in best-performing states, with more than 19,000 avoidable hospitalizations annually
- Diabetes admission rates are four times the rate of hospital admissions in best-performing states, with 14,000 avoidable hospitalizations

50% of All Pennsylvanians Age 18 – 65 Have at Least One Chronic Disease



Chronic-disease patients account for 80% of all healthcare costs and hospitalizations, 76% of all physician visits, and 91% of all filled prescriptions

These chronic-disease conditions are exacerbated in Pennsylvania by

- obesity: overweight and obesity incidence increased nationally by 19% from 1992 to 2002
- an older population: 1 in 5 Pennsylvanians is older than 60

3 Goals: Geisinger focused innovation efforts on improving outcomes and processes for chronic conditions

History of patient-centered medical home

- First championed by the American Academy of Pediatrics, a medical home is broadly defined as primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective
-

History of patient-centered medical home

- Developed by four primary care specialty societies in the U.S., representing more than 30,000 internists, family physicians, pediatricians, and osteopaths
-

Joint principles of the patient-centered medical home

- Personal physician
- Whole-person orientation
- Safe and high-quality care (e.g., evidence-based medicine, appropriate use of health information technology)
- Enhanced access to care
- Payment that recognizes the added value provided to patients who have a patient-centered medical home

4 Changes to patient care: Geisinger's ProvenHealth Navigator is an advanced medical-home approach, ensuring round-the-clock access to a wide range of services

a Access to a set of basic services¹

- Primary care
- Specialty care
- Geisinger-funded nurse care coordinator at each practice site

b Predictive analytics to identify risk trends

c A personal care navigator to respond to patients' inquiries

- Ensures application of evidence-based care
- Prevents further hospitalizations



d Interactive voice response surveillance

e Virtual care management support

f Support for end-of-life decisions

¹ Services are provided by Geisinger and vetted non-Geisinger referral providers
SOURCE: Paulus RA, et al. Health Affairs 2008; Commonwealth Fund 2009

5 Services are underpinned by EHR system, physician incentives, and performance management

Description

1 EHR system

- Available to non-Geisinger referring physicians and patients through customized Web portals
- Patient features include Internet-based lab results, clinical reminders, self-scheduling, secure e-mail with providers, prescription refills, and educational content

2 Practice-based payments

- Geisinger Health Plan (GHP) offers \$1,800 per month to each physician, as compensation for expanded scope of work
- Additionally, GHP offers monthly stipends of \$5,000 per thousand Medicare members to support additional staff for extended hours
- Incentive payments are split among individual providers and the practice, to fill the gap between expected and actual costs of care for medical-home enrollees
- Actual payments are prorated based on the percentage of targets met for ten quality indicators

3 Performance reports

- Monthly performance reports of quality and efficiency results are provided to each medical-home practice and reviewed by an integrated GHP practice site team
- During the review, which includes senior managers from the community practice, challenges and opportunities are identified, and plans are adjusted

6 Key success factors: Successful implementation depends on the alignment of incentives among stakeholders and the EHR system

Align incentives with physicians in care settings and from different health systems

- Create value by linking financial budgets and quality outcomes, paralleling pay-for-performance initiatives
- Encourage, engage, and adequately reward clinician champions – at all levels – who support transformation

Adopt a functional EHR platform to ensure knowledge transfer throughout the system, and to those who know how to use and maintain it

- Recognize that realizing benefits of implementation, adoption, and usability comfort takes time
- Empower patients through home use of the system to make appointments and track health information
- Automate care, remove geographic barriers, and improve reliability

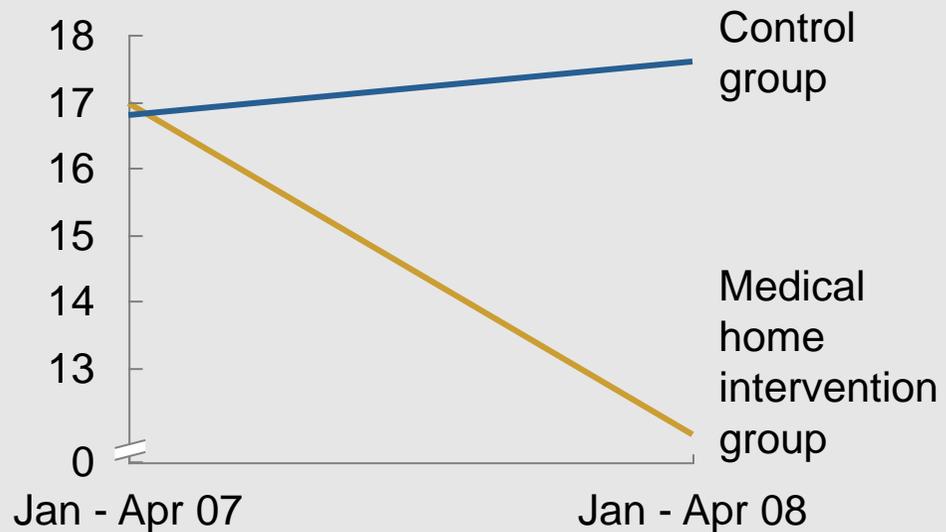
8 Impact: After 1 year, preliminary results show significant achievements

- In phase one (2006-2007), medical costs decreased by 4% for the entire population
- Return on investment was 250%

“Preliminary data show **20% reduction in hospital admissions and 7% savings in total medical costs**”

In phase two, primary target outcome was reduced hospital use

Readmission rates among two pilot sites



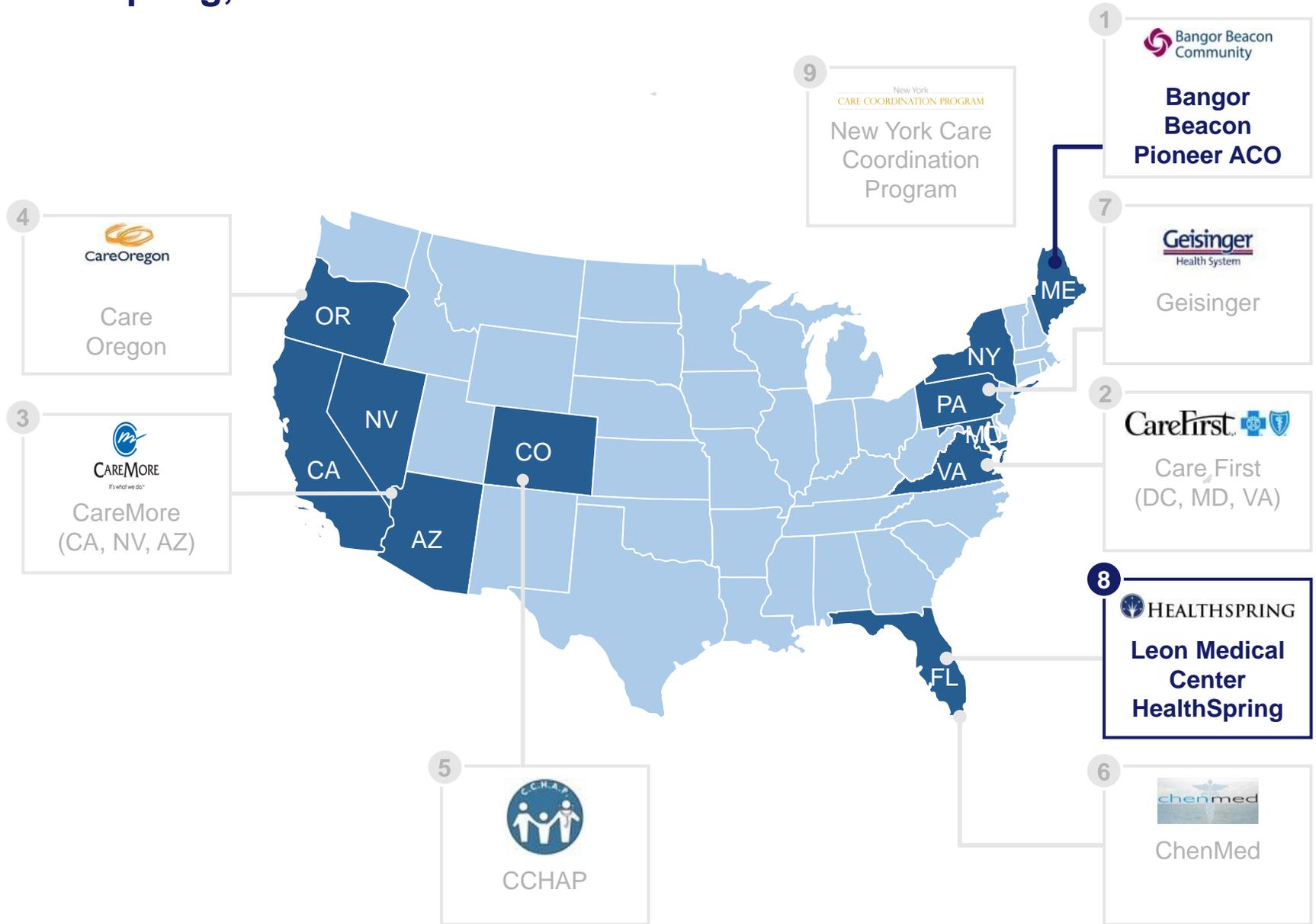
Based on this success, Geisinger is expanding the initiative to ten additional practice sites and one non-Geisinger practice to cover more than 25,000 Medicare Advantage and fee-for-service Medicare patients

9 Lessons learned: Who could implement this initiative?

Thought-starters for creative replication/diffusion

- A payor/system that pays for care, provider, or integrated system could implement this initiative
- For full implementation, a system would need to have the following traits:
 - Convening power and ability to implement an EHR system throughout a large provider network (leveraging economies of scale, given high Internet technology investment)
 - Can support collaboration and coordination of policies among private insurers and public programs
 - Takes a business-like approach to clinical translation, drawing on lessons from other industries, for applicable insights
 - Has the capacity and willingness to take risks and experience failure, to learn, and to push the boundaries of innovation

HealthSpring, Leon Medical Center



HealthSpring's Partnership for Quality (P4Q) at Leon Medical Center

Why was a change in care delivery considered?

- HealthSpring and Leon Medical Center entered into a partnership in October of 2007
- Both entities had been operating separately to alleviate the problem of uncoordinated care of Medicare beneficiaries
- Leveraging care coordination model and effective reimbursement model would enhance the shared goals of both health plan and medical center

What was the scope of the care model?

- HealthSpring LMC health plans offer Medicare Advantage benefits to beneficiaries in the Miami-Dade area
- Program aimed to provide care coordination and preventive care
- Quality improvements and cost savings were used as quantitative measures of success

What were the changes made?

- Care coordination was enabled by care teams and shared IT platform
- Patient engagement was facilitated by the addition of in-office nurses, allowing PCPs more time and additional staff to educate patients

How was the care model put in place?

- HealthSpring first tested its P4Q payment model in 2004
- 2007 purchase of LMC merged two entities serving Medicare populations and targeting chronic conditions

How did payment reform support care model?

- Health plan bears financial risk by paying all of the up-front costs of additional resources
- Bonuses are tied to clinical outcomes
- Incentive structure encourages coordination across care settings

What was the impact in terms of quality and costs?

- No results specific to the HealthSpring-LMC health plan are available to date
- P4Q program saw increase rates of preventive care and reduced healthcare utilization
- Per member cost savings were estimated at 35% in 2007

1 Why was a new care delivery model considered?

What was the overall context? Why was this initiated?

- Many elderly with multiple, costly chronic conditions, with ~65% of Medicare having >2 chronic conditions beneficiaries accounting ~95% of spend
- Existing primary care model better serves single, acute illness and not chronic disease
 - PCPs work in administrative burdensome systems with many short appointments and little time for patient education
 - Reimbursement system does not fund care managers or practice coordinators that could
- Patient-centered approach to care was needed, particularly in the Medicare population

Who was involved in initiating the change?

- HealthSpring, first piloted their Partnership for Quality (P4Q) payment model for Medicare Advantage enrollees with Sumner Medical Group in Tennessee in 2004
- Leon Medical Center, established in 1996, has a reputation for providing concierge-like supplementary services to its Medicare beneficiaries
 - LMC exclusively provides care to Medicare beneficiaries in the Miami-Dade County

How were people brought together? What circumstances helped facilitate that?

- HealthSpring's P4Q payment model had been successful in Medicare Advantage populations in Alabama, Tennessee, and Texas
- 2007 purchase of LMC Health Plans allowed health plan entry into the Florida market, one of the largest Medicare markets in the country



2 What was the scope of new care delivery model?

	Description
Patient Population	<ul style="list-style-type: none">▪ Leon Medical Center covers ~39,000 Medicare beneficiaries▪ Hispanic Medicare community of South Florida is specifically mentioned in LMC mission statements
Geographic Scope	<ul style="list-style-type: none">▪ LMC is the operator of nine Medicare-only medical clinics located throughout the Miami-Dade County
Patient segments & pathways	<ul style="list-style-type: none">▪ Cigna HealthSpring LMC Health Plans exclusively services the Medicare population▪ Program targets chronic condition patients, particularly those with multiple diseases
Providers involved	<ul style="list-style-type: none">▪ Leon Medical Center includes 9 clinics and 70 primary care physicians
Payors involved	<ul style="list-style-type: none">▪ LMC establishes LMC Health Plan as HMO in 2005▪ HealthSpring purchased LMC Health Plan in 2007▪ Cigna purchased HealthSpring LMC Health Plan in 2012

3 What were the goals of the new care delivery model?

	Description
Patients	<ul style="list-style-type: none">▪ Health Spring and LMC aim to better manage care for the Medicare population that sees a greater burden of chronic conditions▪ Patient self-management is enabled by patient education and ongoing support from care coordinators and social workers
Quality	<ul style="list-style-type: none">▪ Improve quality of care by tying a degree of physician financial compensation to achievement of quality metrics▪ Quality can be greatly improved by addition of case managers and practice coordinators
Costs	<ul style="list-style-type: none">▪ HealthSpring strives for at least 15-50% of physician compensation to be based on performance-based variable
Physicians	<ul style="list-style-type: none">▪ Engage physicians using a physician-designed payment model▪ Align incentives across physicians, nurses, care coordinators, and other medical staff
System working	<ul style="list-style-type: none">▪ Using value-based payment to incentivize effective care<ul style="list-style-type: none">– Reimbursement model aims to give providers the time and resources to allow proper patient engagement and education– HealthSpring strives to have 15-50% of physician compensation based on performance-based variables

SOURCE: South Florida Business Journal, "Leon Medical Centers offers model for health care reform," July 26, 2012, HealthSpring press release: "HealthSpring Unveils 2013 Medicare Advantage Plans with More Choices," October 1, 2012, Health Affairs, "American Medical Home Runs," September/October 2009.

4 Care delivery model focuses on preventive care and care coordination



Leon Medical Center HealthSpring plan



Leon Medical Center services

- **Care coordinators** in medical center lobby direct and accompany patients to appropriate care setting
- **Complimentary transportation**
 - Encourages regular clinic visits for preventive care
 - Medication delivery improves likelihood of patient prescription compliance
- **Healthy Living Centers**
 - Increases physical activity at fitness centers staffed with personal trainers
 - Attracts patients with recreational classes such as Latin Dance and Computer Skills

HealthSpring Medicare Advantage providers

- **Additional staff** allows patients access care team of doctors, nurses, case managers, social workers, and pharmacists
- **IT support** improves
 - Improves patient compliance by reducing missed health screenings and prescription refills
 - Disease registry technology standardizes care by improving compliance with key quality metrics and evidence-based medicine
- **LivingWell Health Centers** offer affordable fitness options
- **Personal Assistant Liaison (PAL)** program provides one-on-one support so members manage their own care

Technology across settings share platform

- **LMC reception:** Administrative staff access EMR applications to schedule appointments, check in patients, and answer questions
- **Primary care practice:** Medical assistants, doctors, and nurses use applications to view a patient's history, tests, and x-rays, and to gather new information
- **Exam room:** Physicians and other clinical staff have portal to check the Internet and the company's own resources on the spot to provide patients details and print-outs on their conditions
- **Community care:** Other users include area managers, transportation coordinators, primary care physicians, specialists, dentists, urgent care stations, and pharmacies

SOURCE: South Florida Business Journal, "Leon Medical Centers offers model for health care reform," July 26, 2012, HealthSpring press release: "HealthSpring Unveils 2013 Medicare Advantage Plans with More Choices," October 1, 2012

5 What were the operational changes in how care is delivered?

Primary care

- **Disease management nurses** improved management of multiple chronic conditions in Medicare beneficiaries
- **Extra in-office nurses** allow for nurse practitioners (RNs) to assume PCP roles, registered nurses to assume RN roles... expand PCP workforce in a cost-efficient manner

Community care

- **Dedicated disease/care management team** includes RNs and social workers provide services including telephone-based patient education, medication monitoring, and follow-up to make sure

Hospitals

- **Improved care coordination** at clinic reception is supported by IT enhancement
- **Transportation and recreational offerings** encourage regular and appropriate use of preventive care

Across settings

- **Conceptual “Ambulatory ICU”** improves care delivery: Extensive door-to-door patient transportation service including medication delivery, specialist visits, and on-premises urgent care observation bay are used to assess common acute symptoms common in senior populations
- **Shared IT platform** supports care coordination and reduces variation in care delivery by ensuring evidence-based medicine

6 How were key success factors addressed?

Summary of key elements



Organization and Accountability

- HealthSpring bore all financial risk by paying up-front costs for additional nursing staff
- LMC management remained after partnership with HealthSpring in 2007



Clinical leadership and culture development

- P4Q was a physician-developed program
- PCP as gate-keeper encourages care coordination
 - Care team expanded with additional resources
 - Incentives encourage collaborative approach to care delivery



Information sharing

- Technology platform is synced between clinic reception, primary care practice, exam room, and in community settings such as urgent care centers and pharmacies



Aligned incentives

- Providers were not penalized and would only stand to gain if they hit certain quality metrics
- Bonuses are offered care coordinator, nurses, and other staff, with additional practice-wide bonuses for utilization reduction



Patient engagement

- Patient education is provided during visit to allow self-management
- LMC offers supplementary services to engage patients
 - Complementary transportation services to clinics
 - Clinics offer recreational and socializing opportunities

6 Partnership for Quality (P4Q) delivers positive financial incentives to physicians

Overview and incentive structure

- Health plan bears greater financial risk than provider
 - HealthSpring pays the up-front costs of additional staff and IT resources
 - Physicians receive financial bonuses when they meet clinical targets but are not penalized when they don't
- Physician compensation based on 25 measures of quality and clinical outcomes
- HealthSpring and LMC share equally in the surplus/deficit of the health plan relative to targeted medical loss ratio of 80%

Aligning individual incentives

- Physician bonus: up to a maximum of 20% of historic compensation
- Care coordinator bonus: Care coordinator receive per member, per month bonus when metrics are met
- Bonuses for nurses and other medical staff are allocated at the discretion of the physician
- Practice-wide bonuses (up to 33%) are available for reducing utilization

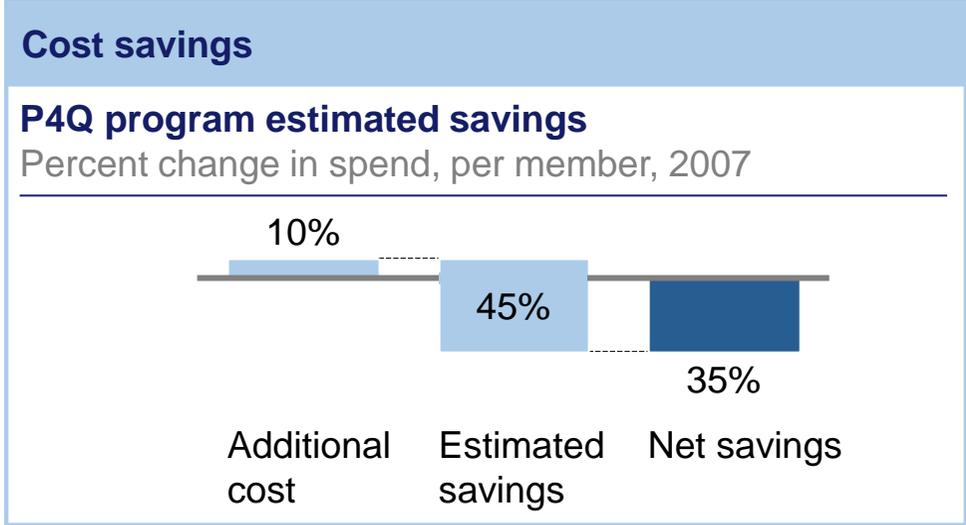
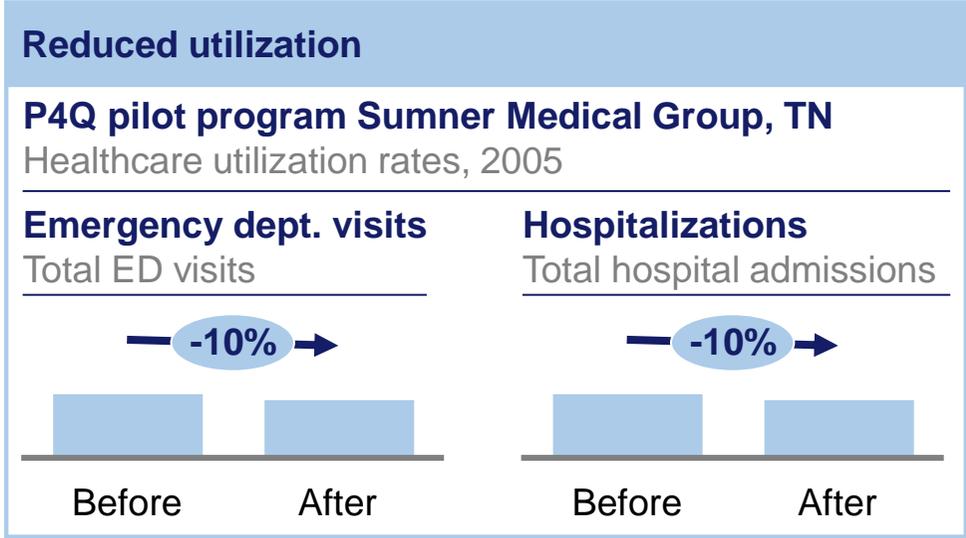
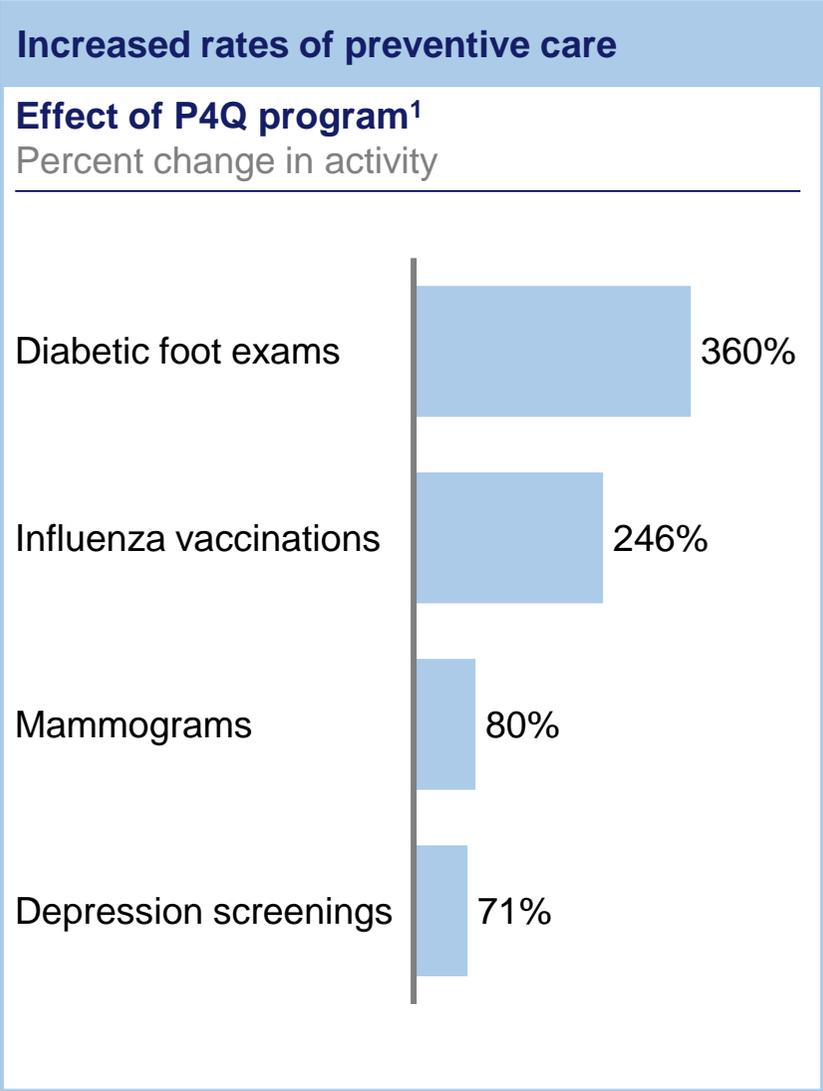
Operationalizing the payment model

- HealthSpring launched the first P4Q pilot at Sumner Medical Group and 8 other practices in Tennessee in 2005
- Following results of improved clinical outcomes and preventive care and reduced medical costs, P4Q was rolled out nationally
- HealthSpring purchased Leon Medical Center Health Plan in 2007

7 How was the care model put in place?



8 What was the impact in terms of quality and costs?



¹ Program-wide results not specific to Leon Medical Center

9 What advice would you give to organizations who are designing a new care delivery model?

Do's



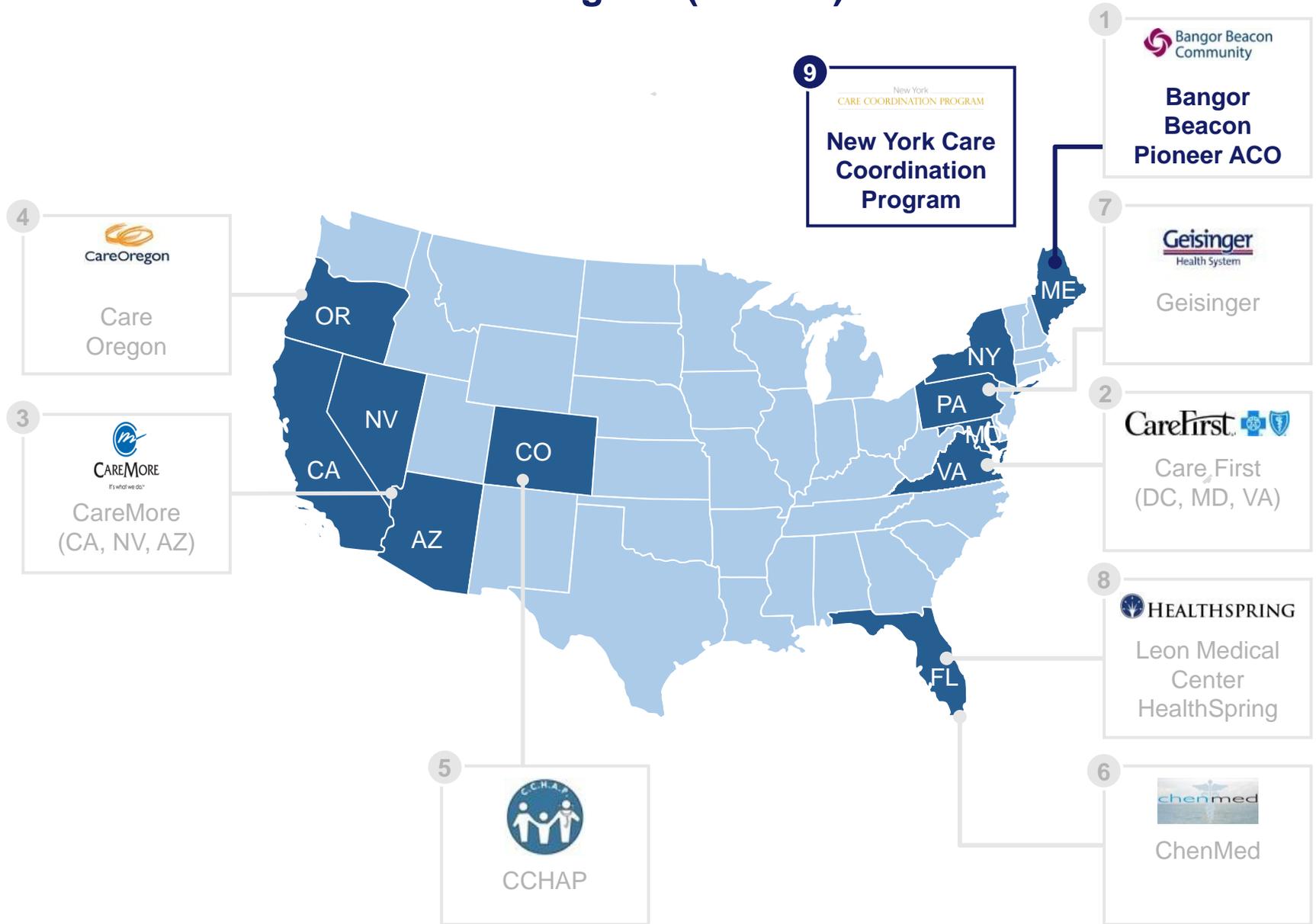
- Engage physicians in program design to ensure provider buy-in
- Supplement care delivery model with payment model to support financial sustainability
- Non-clinical supplementary services can be used to increase patient engagement with the clinical setting

Don'ts



- Unclear whether program would work under FFS model
 - Results stemmed from managed care, capitated payment system with emphasis on primary care services
- Program is specific to management of chronic disease profile of the elderly population
 - Impact may be lessened or lacking when applied to different sub-populations, such as children and adolescents

New York Care Coordination Program (NYCCP)



New York Care Coordination Program (NYCCP)

Why was a change in care delivery considered?

- NYCCP is a not-for-profit collaborative project initiated in 2000 by six counties in NY and NY Office for Mental Health
- The aim was to transform the care for Medicaid patients with SMI (serious mental illness) to provide patient-centered, recovery-focused, evidence-based care, and complex case management for those with highest risks/needs
- The goals were to empower patients, improve outcomes and manage costs

What was the scope of the care model?

- The program targets high-needs Medicaid adult members with SMI:
 - Repeated hospitalizations and incarcerations
 - Frequent crises
 - Lack of constructive social /family network
- Specifically focused on managing mental health costs, but may also address total costs of care

What were the changes made?

- Regional single point of access (SPOA) identifies and enrolls eligible patients
- Individual care plans developed that are 'least restrictive, most normative'
- Highest risk patients given case management and priority access to services
- Focus on rehabilitation, recovery and cultural competency

How was the care model put in place?

- Effort was led by a regional consortia
- Staff hired and first patients enrolled in 2002
- In 2009, behavioral health service delivery and complex case management outsourced to Beacon Health

How did payment reform support care model?

- Evolved from FFS with P4P to risk-adjusted capitation with P4P at three levels which rewards:
 - Improvements in access for priority populations
 - Patient-centeredness
 - Recovery and community integration outcomes

What was the impact in terms of quality and costs?

- 31% increase in patients in gainful activity; 25% fewer arrest; 53% reduction in rate of physical harm to others; 54% reduction in self-harm; 46% reduction in ER visits; 53% reduction in inpatient visits
- Lower annual growth in MH costs, 2.8% vs. 4.4% 5-yr CAGR (2003-2008), resulting in 29% lower average mental health costs per capita (in 2008)

1 NYCCP care delivery model evolved over 10 years with input from a wide range of state, county, provider and patient group stakeholders

What was the overall context? Why was this initiated?

- In the late 1990s, NY state counties formed regional consortia to bid for Special Needs Plans (SNPs) to provide managed care to the behavioral health population
- The state legislature failed to reauthorize the SNP project, but the consortia continued to develop plan to transform services for adults with severe mental and behavioral health conditions

Who was involved in initiating the change?

- The program was led by six counties in Western New York (Chautauqua, Erie, Genessee, Monroe, Onondaga, Wyoming) working with the New York state Office of Mental Health, community providers and support services, patients and families
- The program expanded from 2002 to cover additional counties, Cayuga, Cattaraugus, Chemung, Madison and Rensselear, with Westchester joining to 2010
- In 2009, NYCCP expanded its efforts to develop a managed mental health care delivery system by contracting with Beacon Health Strategies

How were people brought together? What circumstances helped facilitate that?

- Multi-stakeholder composition of Board – 25.5% patients/families, 25.5% providers, 49% county directors – ensures collaborative approach
- Involvement of families has been critical to the program's success



2 NYCCP targets Medicaid members with serious mental health issues

Description

Size of population targeted

- ~3,000 patients across the region – from a total population of 2.8m - with the high SMI needs are targeted for recovery-focused care coordination
- ~200 SMI patients with highest –risk needs – co-occurring mental, physical and substance use disorders - receive intensive, complex care coordination

Spend targeted

- The program targets total Medicaid mental health costs

Patient segments & pathways

- Adults diagnosed with serious mental illness:
 - History of repeated hospitalizations and/or incarcerations
 - Frequent crises
 - Absence of constructive social or family network
 - Lack of meaningful activity
 - Difficulties engaging with treatment, taking prescribing medications and/or managing their symptoms
- Program beginning to cover children with serious emotional disturbances (SEDs)

Providers involved

- Community mental health providers
- Coordinated Care Inc – complex case management provider since 2002
- Beacon Health Solutions – complex case management provider since 2009

Payers involved

- Medicaid

3 NYCCP aims to deliver patient-centered, recovery-focused care

Description

Patients

- Delivery of patient-centered, recovery-focused, individualized, coordinated care covering mental and behavioral health, chemical dependence, physical health, legal, housing and other social support

Quality

- To address the 25 year gap in life expectancy that exists between people with SMI and the general population by:
 - Ensuring people with SMI have access to treatment for medical conditions and modifiable risk factors:
 - Medications management – especially atypical antipsychotics which are associated with weight gain, dyslipidemia and impaired glucose metabolism
 - Smoking and substance misuse
 - Weight management, nutrition and physical activity
 - Health prevention and health promotion
 - Poverty and social isolation
 - Addressing a broad range of determinants of mental health including:
 - Engagement in gainful activity
 - Reduction in self harm, suicide attempts and harm to others

Costs

- To minimize the increase in per capita mental health costs by managing ER visits and inpatient mental health length of stay

Clinicians

- Education and training, learning communities, online tools (www.recoveryskillbuilder.com) measuring, training trainers, champions, webinars and mentoring

System working

- To coordinate access to all services that influence outcomes for people with SMI through coordinated systems and complex case management

4 NYCCP – Care delivery processes

Care delivery model

- **Primary care:** Assigned to primary care physician
- **Care team:** Tiered care coordination
 - For all: care coordinator (CC)
 - For complex case mgmt: partner with Beacon case mgrs, BH and PH providers
- **Performance mgmt:**
 - Close monitoring of outcomes with scheduled CC patient reporting requirements
 - Improvement initiatives based on actual outcomes, designed via collaboration with stakeholders
 - Program SteerCo, with reps from all govt units, providers and consumers, makes decisions about program values, goals and initiatives

Care coordination process					
Patient ID/enrollment	Initial assessment	Care plan	Monitor/outreach	Ongoing care	
<ul style="list-style-type: none"> ▪ Single point of access (SPOA) for enrollment across each county ▪ Adoption of standard target system with claims data from NYS OMH ▪ SPOA orgs refer patients to care coordinator, who will try to make face-to-face contact patient within 7 days¹ 	<ul style="list-style-type: none"> ▪ Assists individual in completing a Quality of Life Self-Assessment, ▪ Initial basis for a personalized care plan ▪ Use of level of care criteria to determine needs 	<ul style="list-style-type: none"> ▪ Care plan developed by care coordinator and patient within 30 days of contact ▪ Identified services must include treatment, rehab, support, self-help, empowerment services ▪ All provides receive copy of plan ▪ Back-up crisis plan if patient is non-compliant 	<ul style="list-style-type: none"> ▪ Based on care plan, outreach to providers to arrange necessary services ▪ Care mgr monitors patient use of services weekly and conducts monthly review of patient progress ▪ Meets with patient min of 1x/6 months to review progress and update plan 	<ul style="list-style-type: none"> ▪ Complete periodic reporting form and outcome reports on patient ▪ Work with patient and govt agencies to maintain Medicaid eligibility, housing and other social services ▪ Work with counties to monitor patients (e.g., post-incarceration) 	

Technology integration

- Standardized SPOA online application and enrollment system across counties with centralized database

¹ If immediate assistance is required, will meet in person with patient within 48 hours depending on safety / risk
 SOURCE: NYCCP website (<http://www.carecoordination.org>)

5 NYCCP forms a network of out-of-hospital services

Case management

- Complex case management outsourced to specialist external providers:
 - Coordinated Care Services Inc.
 - Beacon Health Solutions

Outreach

- Outreach personnel visit club houses, shelters, churches, libraries and parks etc

Community providers

- A network of 29 community-based organizations provide referrals (to the program) and deliver care

Clinicians

- Clinicians engage with clients for initial intake, weekly telephone coaching, quarterly face-to-face appointments and re-assessment every 6 months

Peer support

- Peer navigator makes connections to social and medical services, adds credibility, serves as a role model

Other services

- Social support
- Housing support

6 How were key success factors addressed?

Summary of key elements



Organization and Accountability

- Standards are set for organizations not individual clinicians
- Provider participation is voluntary
- Locally-defined quality improvement plans
- County-level planning and contracting



Clinical leadership and culture development

- Suite of evidence-based tools developed to support clinicians in the transition towards more person-centered care
- Intensive training for specific professional roles, especially care coordinators and community mental health providers



Information sharing

- Standardized, shared online enrollment system
- Quarterly sharing of performance measures



Aligned incentives

- A tiered program of incentives which reward improvements in:
 - Access to care for priority populations
 - Implementation of person-centered care practices
 - Recovery and community integration outcomes



Patient engagement

- Peer wellness coaches and navigators provide support and role models
- Local community meetings for family members

6a How did the payment model align incentives?

Relevant questions

Overview and guiding principles

- In the early years, NYCCP was funded using Medicaid FFS with additional P4P elements, while 'single checkbook' system developed
- From 2013, NYCCP will contract to deliver risk-bearing, capitation-funded Medicaid managed care – with funding pooled from multiple sources in 'single checkbook' system

Aligning individual incentives

- Pay for performance rewards available at three levels:
 - Level I – based on achievement of baseline contacted incremental improvements in local priority population performance standards
 - Reimbursement up to incurred deficits
 - Funding flexibility across program and funding source codes
 - Level II – based on achievement of mid-level performance standards
 - As level I plus reimbursement up to the full contracted program budget regardless of incurred deficits with restriction on use of funds retained in excess of incurred deficits
 - Level III – based on meeting/exceeding highest standards of care
 - As level II plus performance premium

Mechanisms to mitigate volatility and risk

- Risk allocation model used to adjust capitation payments
- County-level risk corridor option available

Operationalizing the payment model

- NY OMH approved waivers to give the NYCCP providers greater flexibility to implement new care delivery models: permission to co-enroll individuals to multiple programs; elimination of restrictions on rehab treatments; expansion of reimbursement to cover non-traditional services; greater flexibility for outreach programs; expedited licensing

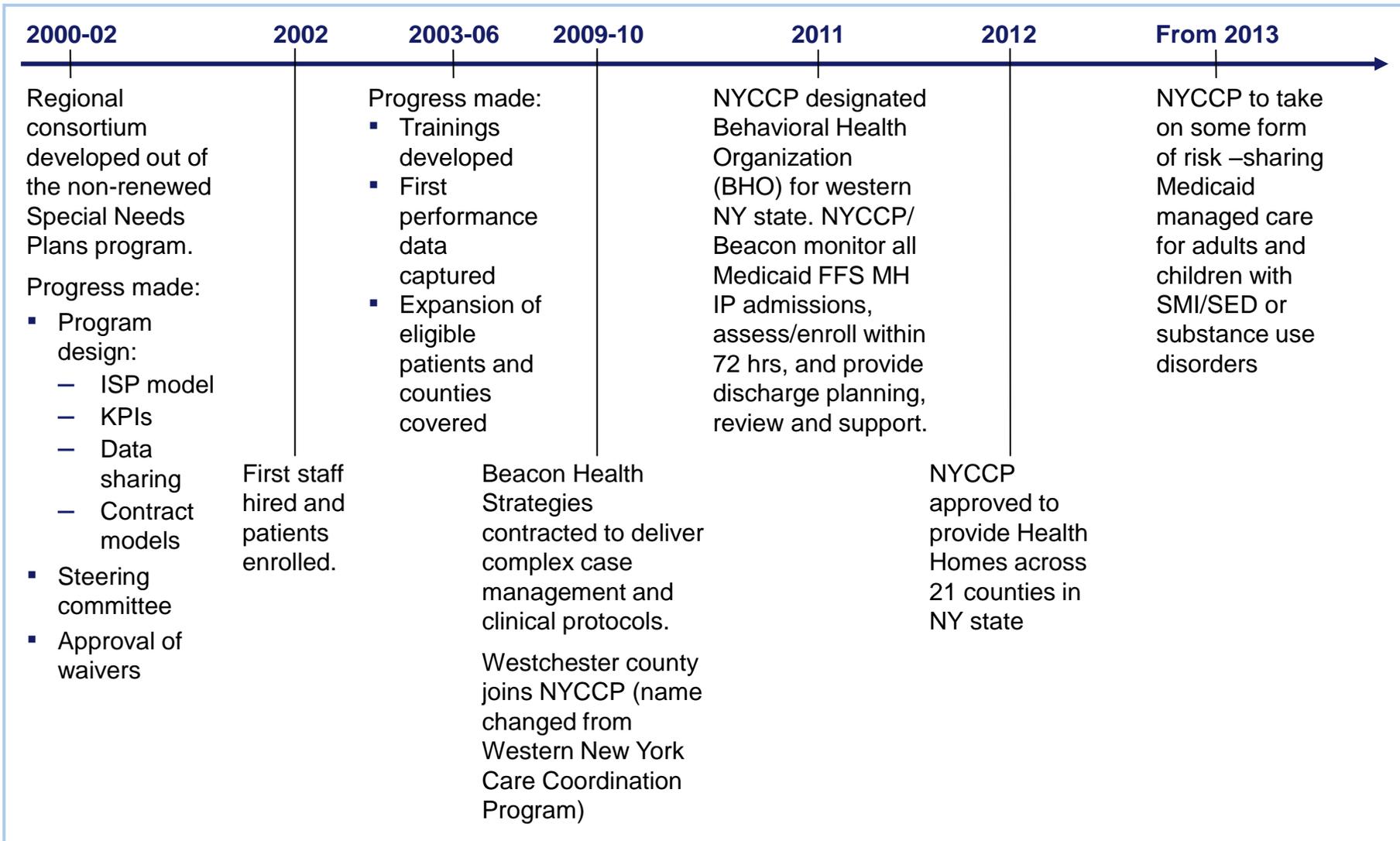
6b NYCCP's care plans are evaluated for person-centeredness

Performance criteria for individual care plans

1. The person's dreams, interests, preferences, strengths and capacities are explicitly acknowledged and drive activities, services and supports
2. Services and supports are individualized and don't rely solely on pre-existing models
3. The person has a presence in a variety of typical community places. Segregated services and locations are minimized
4. Planning activities occur periodically and routinely. Lifestyle decisions are revisited
5. A group of people who know, value, and are committed to the person remain involved



7 How was the care model put in place? (2/2)

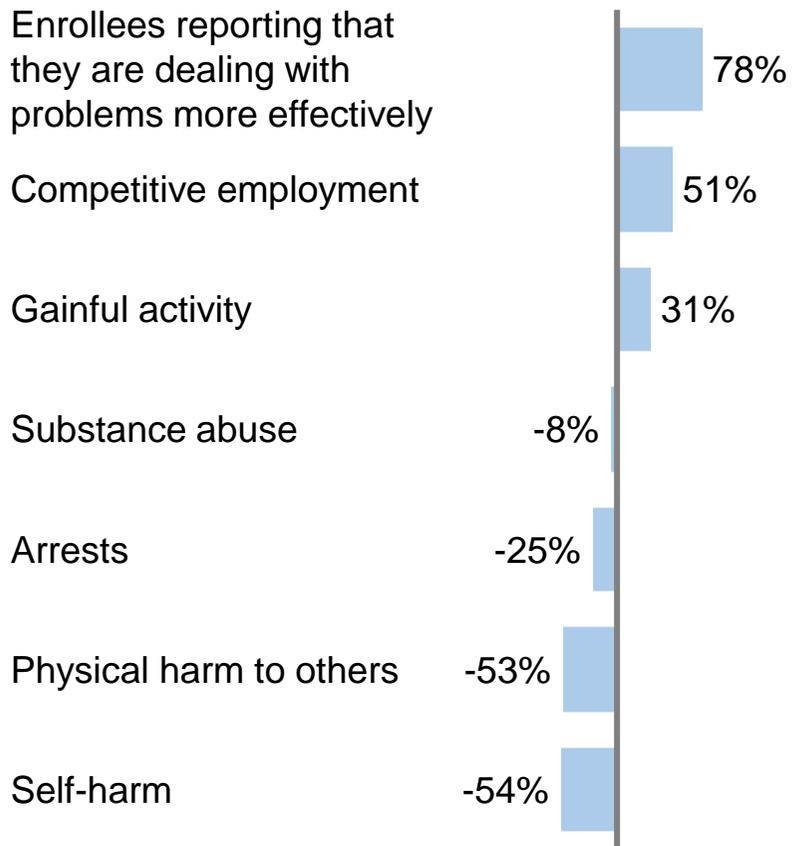


8 NYCCP has reduced costs by 29% by shifting to community settings

XX% CAGR

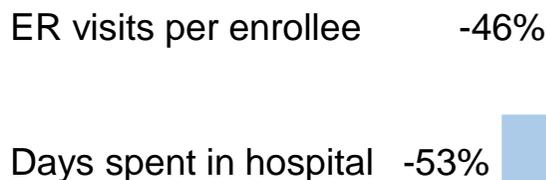
Impact on health and quality of life

Change from patients 1st assessment to 2009 assessment - %



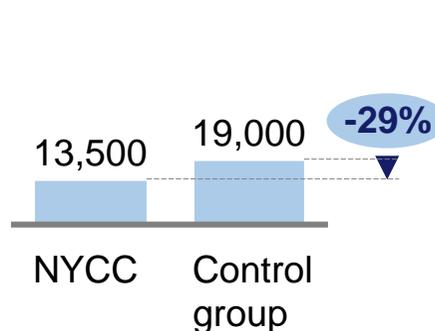
Impact on utilization

Change from patients 1st assessment to 2009 assessment - %

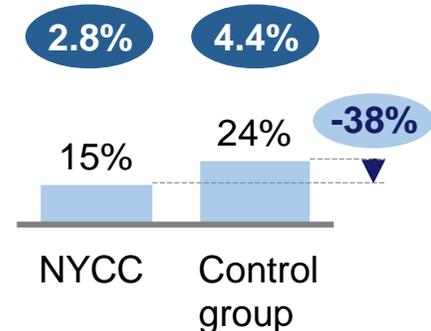


Impact on costs

Annual per capita mental health costs, 2008



Increase in MH costs per capita, 2003-2008



9 For the NYCCP success has depended upon sustained, intense programs of care delivery

Lessons learned



- Progress is possible but it takes **time and intensity**
- Benchmark against SMI populations – as comparisons to the general population are not helpful
- The program has been **delivered in phases to lessen disruption** to existing services and financial risk

Challenges



- **Sustainability** needs to be addressed – e.g. through **peer wellness coaches**
- It may be possible to improve performance further by speeding referral to response times (currently 7 days)