Population Health: Moving Beyond ACOs

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March 2, 2015
Executive Summit
Just what is “Population Health”

• “The health outcomes of a group of individuals…”

• Health accountability for a defined group

• What defines the group?
  • The group
  • Geography
  • The payor
  • The hospital / system
  • Defined “borders”
  • In and out “freedoms”
  • A group of providers / physicians
    • Primary Care
    • Specialty
  • A disease or procedure
What happened to the Individual?

... including the distribution of such outcomes within the group

- Doctor / Patient relationship
- We all die
- Outcomes – add significance to accountabilities
IHI Population Health Composite Model

It's not about the Money!...

IT’S ABOUT THE MONEY!!!
Healthcare Reform: Jumping the ‘S’ Curves

Heads in Beds

A

B

Tough to go from Volume/FFS to Capitation/Value

Value
ACA – Health Care reform
Insurance reform?
Health Cost reform?
Healthcare

The Blood on the floor…

is yours!

PAIN ➔ CHANGE

OR

No change without changing incentives!
Taking Risk for Population Health (Group)

- Reverses volume incentives
- Focus on health, not volume
- Results in Improved Health Status
- Reduces hospital admissions / readmissions / ER visits
- Reduced Costs = Increased Margins
- EBITDA can double under risk
Key Population Health Actions

- Group definition and “premium” portion at risk
- Physicians on salaries
- Primary care base
- Data analytics on outcomes, cost, physicians, episode treatment groups patients
- Predictive modeling
- Case / care management
- Focus on Behavioral Health
- Community Health Workers
- Transitions in care
New Mexico Health Connections

- ACA Health Plan Cooperative
- Fully “at risk”
- Analytics and Medical Management double down
- Behavioral Health
- Community Health Workers
- Full physician practice cost and outcomes internally transparent to physicians
NMHC 2014 Results

- Robin Hood
- Admissions / 1,000 – 32 vs 54 benchmark
- Readmissions – 5.2 vs 12 benchmark
- MLR 73%
- Mount Auburn Cambridge IPA
- Primary Care Shared Savings to large group full risk delegation
- Primary Care W-2 goal in 2018 is $350,000
Ascension’s Journey to Value-Based Care and Population Health

Robert J. Henkel, FACHE
President and Chief Executive Officer, Ascension Health
Executive Vice President, Ascension
OUR VISION CALLS US TO STRENGTHEN THE CATHOLIC HEALTH MINISTRY

OUR MISSION

Rooted in the loving ministry of Jesus as healer, we commit ourselves to serving all persons with special attention to those who are poor and vulnerable. Our Catholic health ministry is dedicated to spiritually centered, holistic care which sustains and improves the health of individuals and communities. We are advocates for a compassionate and just society through our actions and our words.

OUR VISION

We envision a strong, vibrant Catholic health ministry in the United States which will lead to the transformation of healthcare. We will ensure service that is committed to health and well-being for our communities and that responds to the needs of individuals throughout the life cycle. We will expand the role of the laity, in both leadership and sponsorship, to ensure a Catholic health ministry of the future.

OUR VALUES

Service of the Poor
Generosity of spirit, especially for persons most in need

Reverence
Respect and compassion for the dignity of diversity of life

Integrity
Inspiring trust through personal leadership

Wisdom
Integrating excellence and stewardship

Creativity
Courageous innovation

Dedication
Affirming the hope and joy of our ministry
Ascension is the largest Catholic health system, the largest private nonprofit system and the second largest system (based on revenues) in the United States, operating in 23 states and the District of Columbia.
Approach to Population Health

A key strategic priority for Ascension is to create clinically integrated systems of care in our markets that enable us to deliver on the Quadruple Aim – improved health outcomes, improved experience for those we serve, and improved experience for providers, at a lower overall cost of care.

- Ascension is building the internal capabilities to enable value-based care in order to manage the health and well being of the populations we serve.
  - Building regionally-based clinically integrated systems of care to manage Medicare, Medicaid, Exchange, and Commercial populations, as well as our associates
  - Assembling capabilities in network development/management and innovative approaches to care management
  - Developing a central risk function to manage and pool risk
  - Creating a System-wide enterprise architecture to support delivery of fee-for-value models

- Ascension markets are moving at different paces to population health business models and risk-based contracting - this provides Ascension with an opportunity to rapidly test capabilities/approaches in certain markets, learn from these pilots and replicate best practices across the System.
Ascension is Developing Capabilities to Take on Greater Risk

**Spectrum of Risk**

*Increasing coordination, commitment, and provider risk*

**Provider**

- Provide care to population as part of a broader provider network
- Create a narrow network product with a health plan
- Partner with a plan using a shared savings approach
- Enter a capitated risk arrangement with a plan partner
- Form a JV and private label a plan with a health plan partner
- Own/operate a health plan

**Payer**

**Required Capabilities**

- Network Development / Management Capabilities
- Care / Medical Management Capabilities
- Risk Management & Reimbursement Optimization Capabilities
- Back Office Capabilities
- Sales and Marketing Capabilities
- IT Capabilities
MissionPoint Health Partners – Innovative Model for Network Development and Care Management

- MissionPoint directly designs, and builds provider networks, deploys health partners who call on patients in the hospital or in their homes, and further supports any additional needs members have to live well and flourish in their community.

- MissionPoint’s clients include integrated health systems, payers and large employers (i.e. entities that have historically organized and taken risk for populations).

- In addition to care management solutions and narrow network development, MissionPoint provides a unique set of products and services directly to employers and payers – such as complex case management, onsite clinics, and a suite of wellness services.
MissionPoint Custom Network Design

MissionPoint Provider Network

MissionPoint Health Partners

Personal Care Team

Per Member Per Month Payment

Shared Savings Pool

Medical Home
Internal Medicine
Family Practice
Pediatrics

Specialists

Outpatient Facilities

Inpatient Facilities

Population Identification and Stratification

Care at a Distance

Wellness Partners and Services

Additional Physician Incentives
Extended Weekday Hours
Open Saturdays
Open Sundays
Email with Patients
Comprehensive Medication Review
Creating Value for the Ecosystem

Options During Open Enrollment

Preferred Network (MPHP)
- Clinically Integrated Network
- Open Access
- Dedicated Medical Home
- Low Co-Pay Levels
- Leveling Monthly Premiums
- Coordinated Patient Record
- Deep Wellness Support

In-Network
- Narrow Network
- Higher Co-Pay Levels
- Rising Monthly Premiums
- Wellness Support

Out-of-Network
- Open Network
- Highest Co-Pay/Co-Insurance Levels
- High Monthly Premiums
- Low Coordination
- Little Wellness Support

Employee Selects Medical Home

Employee/Member

MissionPoint Health Partner

Self-Insured Employer

Payer TPA

Provides Shared Savings Option

Pays Claims and Network Service Fee
MissionPoint Strategic Approach

Targeted, Fact-Based Solutions to Manage Populations

Getting to know you:
- Personal Health Reports
- Clinical Population Analysis
- Demographic Review

Personalized Plans
- Type of Engagement
- Frequency
- Intensity
- Duration

Right Time, Right Place
- Quarterly Monitoring
- Strategy Adjustments
- Quality Reviews

Identify | Segment |Prescribe |Engage |Sustain

Analytics and Aspirations
- Utilization Costs
- Location Costs
- Avoidable Events
- Behavior Modification
- Care Experience

Find the Right Strategy:
- Health Assessments
- On-Site Clinics
- Health Partners
- Telehealth
- Narrow Networks
MissionPoint Approach to Managing Patient Risk

Patient Data Maximized to Guide Effective Interactions

Prioritize Highest Risk Members:
Immediately deploy Health Partners to patients during “trigger events”

Target Members Showing Warning Signs:
Track future risk scores and population trends for pro-active Health Partner engagement

Create Opportunities Across Members:
Leverage highly effective, low cost screenings and preventative care for optimal health outcomes across members

Benefit Design Steers Members Towards Optimal Use of MissionPoint Network
MissionPoint Health Partner Solutions

Diverse Focus Areas Addressed on Three Health Partner Teams

Patient Connects to Health Partner:
- Physician Referral
- Self Referral
- Hospital Discharge
- ED Visit

Transitional
- Hospital Discharge
- Long-term Care
- Skilled Care
- Home Visits

Ambulatory
- ED
- Disease Management
- Wellness
- Office Based Presence

Integrated Care
- Psychosocial Needs
- “Life” Resources
- “Family” Resources
- Behavioral Adaptation
MissionPoint Performance: Self-Insured Population

Continuous Improvement in Self-Insured Population

Total Healthcare Spend vs. Target Spend

Key Performance Metrics by Year

% 30 Day Readmissions

ED Visits per 1,000 Members

Generic Utilization

Percent of Population with a Selected PCP
### MissionPoint Performance: MSSP

#### MSSP Comparison of Calendar Year 2012 to Calendar Year 2013

<table>
<thead>
<tr>
<th></th>
<th>Inpatient Cost per Beneficiary</th>
<th>Outpatient Cost per Beneficiary</th>
<th>Post-Acute Cost per Beneficiary*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>32.33% of Total Spend {2013}</td>
<td>16.71% of Total Spend {2013}</td>
<td>17.48% of Total Spend {2013}</td>
</tr>
<tr>
<td></td>
<td>$3,213 2012</td>
<td>$1,514 2012</td>
<td>$2,018 2012</td>
</tr>
<tr>
<td></td>
<td>$2,986 2013</td>
<td>$1,543 2013</td>
<td>$1,614 2013</td>
</tr>
<tr>
<td></td>
<td>- 7.08%</td>
<td>+ 1.94%</td>
<td>- 20.02%</td>
</tr>
</tbody>
</table>

% decrease from 2012 to 2013

% increase from 2012 to 2013

% decrease from 2012 to 2013

All MSSP ACO Average Change: +0.19%

All MSSP ACO Average Change: +7.37%

All MSSP ACO Average Change: +2.35%

The remainder of spend is comprised of Part B Physician/Supplier (30.59%) and Durable Medical Equipment (2.89%).

* Post-Acute Cost includes Skilled Nursing Facility, Home Health, and Hospice
MissionPoint Performance: MSSP (continued)

**MSSP Comparison of Calendar Year 2012 to Calendar Year 2013**

<table>
<thead>
<tr>
<th>Hospitalizations per 1,000</th>
<th>ED Visits per 1,000</th>
<th>Primary Care Visits per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>357 2012</td>
<td>645 2012</td>
<td>8,887 2012</td>
</tr>
<tr>
<td>335 2013</td>
<td>602 2013</td>
<td>9,018 2013</td>
</tr>
<tr>
<td>% decrease from 2012 to 2013</td>
<td>- 6.12%</td>
<td>% increase from 2012 to 2013</td>
</tr>
<tr>
<td>% decrease from 2012 to 2013</td>
<td>- 6.73%</td>
<td>% decrease from 2012 to 2013</td>
</tr>
</tbody>
</table>

All MSSP ACO Average Change: -3.69%
All MSSP ACO Average Change: 0.00%
All MSSP ACO Average Change: +3.24%

30-Day All-Cause Readmissions

<table>
<thead>
<tr>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>15.99%</td>
<td>14.97%</td>
</tr>
<tr>
<td>% decrease from 2012 to 2013</td>
<td>- 6.36%</td>
</tr>
</tbody>
</table>

All MSSP ACO Average Change: -3.23%

30-Day Post-Discharge Provider Visits Per 1,000 Discharges

<table>
<thead>
<tr>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>710</td>
<td>708</td>
</tr>
<tr>
<td>% decrease from 2012 to 2013</td>
<td>- 0.36%</td>
</tr>
</tbody>
</table>

All MSSP ACO Average Change: +1.79%
Ascension Risk Services

CURRENT PROGRAMS
- Professional and General Liability (PGL) Program
- Workers’ Compensation and Associate Safety
- Certitude Independent Physician Program
- Commercially insured auto, property, Directors & Officers (D&O)

OPPORTUNITIES / AREAS OF EXPERTISE
- Claims Management
- Loss Prevention
- Accountable Care Organization (ACO) Management Risk
- Employer/Provider Stop Loss

INSURE NEW RISKS
- New Ascension business risk (e.g. Ascension Investment Management, The Resource Group, SmartHealth)
- Additional coverage lines (e.g. Catastrophic Medical Risk, ACO Management Risk, D&O, Technology)
- 3rd party health system risks

SCOPE OF SERVICES / SOLUTIONS OFFERED

DEGREE OF INSURANCE RISK ASSUMED
Ascension Clinical Holdings:
Provision of Services to Support a Clinician Alignment Strategy

- Provide physician services that offer a compelling value proposition for employed and strategic partners.
- Offer a portfolio of needed services to physician practices to enable more cost effective practice management while better positioning them to participate as a preferred network.
- Initial offering includes Practice Management and Electronic Medical Record
- Additional offerings include Certitude (medical malpractice coverage) and The Resource Group (GPO)
Alignment with a national physician group, focused on high quality, patient centric care
- Seamless integration with an existing, installed base in-market
- Connection to networked ecosystem
- Participation in care networks

More time to care for patients
- Reduced administrative burden
- Less time managing vendors

Improved bottom line
- Improve the rate of collection
- Avoid costly software implementation
- Expenses incurred in administrative tasks

Retained independence
Ascension Provider Enterprise

A high performing medical group which unites a community of providers employed across Ascension through a common culture that fosters person-centered care as the central principle.

The Ascension Provider Organization develops physician leaders and communities of providers and empowers them to assure a focus on the quadruple aim of:

1. Improved health outcomes
2. Enhanced patient experience
3. Excellent provider experience
4. The lowest overall cost of care

We envision:
• Every regional medical group is a corporation that is a subsidiary of “Ascension Provider Organization” or “Ascension Medical Group”.
• Regional groups are each governed by an interdisciplinary management board focused on quality, service, the provider experience, the cost of care and the sustainability of the provider organization.
AESA Conceptual View

Attributes
• A delivery framework
• Platform Agnostic
• Technology Agnostic
• Application Agnostic
• Vendor Agnostic
• Scalable
• Supports Current and Future Business Needs

Enabled By
• Enterprise Architecture Framework
• Application Architecture & Portfolio Management
• Service Management & Governance
• Data Management & Governance
Financial Models
Introduction

• Martin defined population health and its velocity

• Bob provided deep insights into population health operating model/capabilities

• Now I will focus what makes a successful population health financial model
  • Financial formula
  • Financial operations

Biography

• Actuarial roots, evolved into advisor to payer & provider executives committed to operationalizing the decisions/changes necessary to succeed
• Co-author of industry’s top selling ACO book published by American College of Healthcare Executives
Thesis

• There are 2 primary financial decisions required to create a successful financial model
  • Financial formula, defined in terms of sources and uses of shared savings and shared risk proceeds
  • Ongoing financial management people & process model

• But there is one CEO/Executive Team decision that even the best financial model/CFO cannot “fix” without the help of clinicians and operators
  • Organizational structure & operating model design
Organizational Structure & Operating Model Design

• The *organizational structure and operating model* need to be designed to minimize barriers/politics that physicians, hospitals and insurers encounter when operating under a shared savings or shared risk payment model

• Symptoms of potential problems
  • Managed care team signs $750M risk contract and the health system loses $75M in 12 months
  • Medical management resources / costs quadruple among the hospital, medical group, clinically integrated network and payer(s), without a common “Care Model Blueprint”, frustrating patients and physicians
  • Bonuses never get to those that do the work
  • The Population Health team has 5 people on it; the other 25,000 employees don’t know what Population Health is
Consider 2 Organizational Structures – “A”

In this model, the PCPs, hospitals, specialists in the network all hold different contracts with different payers with different incentives.

Each of the parties have their own EMRs, EDWs, clinical models, contractual relationships that a thin Governance layer and small management team cannot harmonize.

Executive team opportunity to establish common identity, expectations and operating model that finance can help capitalize, reward, contract, budget for.
Consider 2 Organizational Structures – “B”

- In this model, the market leader forms a Clinically & Financially Integrated Network (with or without other co-owners)
- CFIN participants and even payer partners can co-own the Population Health Support Newco, or contract with it for services
Why is An Integrated Financial Model Important?

• Your organization has likely spent millions on population health

• Your organization may be just one bad deal away from scrapping its population health plans

• It’s difficult to take substantive capitated risk AND still manage fee for service payment model, particularly without enough “skin in the game” for providers, payers and consumers.

• So we owe a serious conversation to your action plan to evolve your financial model from a FFS model to a “mixed model” of capitated payments AND fee for service payments.

• The action plan needs to address 2 key sets of choices/decisions:
  • Financial formula, defined in terms of sources of funds and uses of funds
  • Ongoing financial management people & process model
Key Financial Management Choices

• Your sources of shared risk & shared savings funds
  • Which of your system’s patients do you target for a performance based reimbursement model AND/OR narrow network by when?
  • What providers and services will be included in the financial budget our organization will be responsible to achieve, over time?
  • What level of direct investment from payers & providers?
  • Sidebar: What will your system do to mitigate competitive responses, particularly in a “slow-growth” market?

• Your uses of shared savings & shared risk funds
  • Minimum and maximum distribution amounts?
  • Group vs. individual performance weighting and distribution?
  • Improvement vs. achievement impact on distribution?
  • Quality vs. cost vs. citizenship metrics/performance?

• Hardwiring financial management / operations
  • Budgeting best practices
  • Monthly operating report best practices
  • Transparency
Key Financial Management Choices

- Common Straw Model Template

Savings Achieved = 100%
Split 50:50

Payer

100% ACO

25% Reinvest
- Care managers
- Disease mgt.
- HIE expansion
- Management positions

50% To Physicians
- Methodology
  - Set quality targets
  - Point system for achieving targets
  - Cost savings thresholds to be eligible for payout
  - Group level payout and physician level payout, based on performance

25% To Hospitals

Key Features
- Largest share to physicians
- Hospitals eligible for share of savings
- Physicians regardless of specialty have same opportunity to earn savings

Pros
- Directly gives specialists and hospitals incentive to seek performance improvement

Cons
- Potential need to reward certain physicians more than others based on a metric other than performance
Sources of Funds Decisions

• Which of your system’s patients do you target for a performance based reimbursement model AND/OR narrow network by when?

• What providers and services will be included in the financial budget our organization will be responsible to achieve, over time?

• What level of direct investment from payers & providers?

• Sidebar: What will your system do to mitigate competitive responses, particularly in a “slow-growth” market?
Which Patients?

- Which of your system’s patients do you target for a performance based reimbursement model AND/OR narrow network day 1 vs. day 1000?
  - Most systems have 1-5% of their admissions and/or revenue tied to performance based contracts and/or narrow networks
  - Some systems had 10-50% in the 1980s and early 1990s
  - It’s imperative to understand the savings profile of the populations you plan to cover, before you sign risk deals
    - Medicare – major post acute savings opportunities
    - Medicaid – variety of socioeconomic issues, behavioral health
    - Commercial – site of service, avoidable ED, Rx, ancillary and specialty utilization opportunities
  - So anticipate a “mixed financial model”; with some lives under narrow network/risk based payment models; and what that means to your operating and compensation models
Which Providers & Services?

• Many hospital-based provider systems are signing shared savings (no risk) arrangements worth 1-3% of revenue

• Fewer are signing full risk based deals, where if the provider incurs more expense than expected, then the provider owes the payer money

• Payers are increasingly seeking large primary care groups to take on financial risk on primary care & specialty professional expenses and facility expenses over time

• So, once you’ve picked a population (e.g. Medicare Advantage vs. patients in need of hip surgery), you face several different options
  • Take primary care professional expense risk; and/or
  • Take specialty care professional expense risk; and/or
  • Take facility expense risk; and/or
  • Take pharmacy expense risk
Which Direct Investments?

- Typically $0
- Changing as payers & providers recognize the significant operating model changes necessary to achieve sustainable savings
- Joint investment in analytics and hardwiring people, process & technology into care model on highest cost, highest risk patients
Case Study – How a Bad Financial Deal Can Kill a Great Start

- Modestly growing market, with 4 competitors (including 1 AMC)

- ABC CIN recruited 12 key sub-specialists from AMC and gets an exclusive arrangement with BCBS to care for 25,000 HIX lives, 25,000 MA lives and 25,000 POS lives, at risk and under a 10-20% discount relative to current PPO fee schedule

- AMC competitor creates its own CIN and is excluded from HIX, MA and POS populations (except for emergency and super sub-specialty services)

- For profit competitor creates its own CIN, and takes a 15% discount across all populations to keep beds full, without enhancements to its network

- Payer, reeling from MA losses because of under-priced products, aggressively markets for-profit competitor’s network/product where the payer’s margins are the greatest

- Commercial fee schedules decline ~15% across the market and ABC CIN loses 4 commercial market share points in 2 years
Case Study – How a Bad Financial Deal Can Kill a Great Start

- What went wrong?
  - Payers could exclude 1 (or more) from a network
  - So competitors matched/extended your price discounts given short term pressure to “fill beds”
  - Undifferentiated value proposition to independent physicians, let alone consumers, further fragmented the market to the point that physicians terminated their employment agreements and formed a large multispecialty practice aligned with the payers with the most lives

- Pacing the operational, competitive and financial transformation is a critical executive decision.
  - Anticipate strategic moves particularly in fragmented provider markets with significant payer power
  - Establish a clear operational plan that will achieve both market essentiality and value creation within specific populations (e.g., Medicaid managed care vs. commercial vs. chronically ill) in partnership with community providers
Uses of Funds Decisions

- How will you distribute and/or invest shared savings & shared risk proceeds with physicians, hospitals, payers and consumers?
  - Minimum and maximum distribution amounts?
  - Group vs. individual performance weighting and distribution?
  - PCP vs. specialist distribution?
  - Improvement vs. achievement impact on distribution?
  - Quality vs. cost vs. citizenship metrics/performance?
Uses of Funds Decisions

- General Template for Revision

<table>
<thead>
<tr>
<th>Composite Score of Quality, Pt. Experience and Cost Measures</th>
<th>Low Performer</th>
<th>Moderate Performer</th>
<th>High Performer</th>
</tr>
</thead>
<tbody>
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<td>Low Performer</td>
<td>0% of X</td>
<td>16% of X</td>
<td>33% of X</td>
</tr>
<tr>
<td>(Y% of Physicians)</td>
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<td>MAXIMUM = 100%</td>
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<tr>
<td>(Y% of Physicians)</td>
<td>(Y% of Physicians)</td>
<td></td>
<td>(Y% of Physicians)</td>
</tr>
</tbody>
</table>

- Minimum and maximum distribution amounts?
- Group vs. individual performance weighting and distribution?
- PCP vs. specialist distribution?
- Improvement vs. achievement impact on distribution?
- Quality vs. cost vs. citizenship metrics/performance?
Minimum & Maximum Distribution Amounts

- Physician practices aiming for 10-20% of total compensation
- But employers aren’t willing to pre-fund bonus accounts worth 10-20% of medical costs
- So providers need to revise their internal funds flow formulas/accounting accordingly, mindful of fair market value rules
Group vs. Individual Performance, PCP vs. Specialty

- Typically skewed towards individual, when group-wide coordination is the key to unlocking significant savings

- Result is more “pod-level” arrangements, that respect how far, how fast a particular group can change their behaviors

- Generally, more of the shared savings and risk flow to PCPs rather than specialists
Improvement vs. Achievement

- Typically skewed towards achievement, when improvement is typically the priority, out of the gate

- Result is an important message from leadership that overall group-level improvement will be the priority, over the next several years, recognizing some may leave
Metrics & Thresholds

• Typically underweighted in cost and citizenship, which are essential to short-term success

• Typically groups specify a minimum performance threshold to justify any shared savings/bonus payout

• Few groups assess specific financial penalties for underperformance
Case Study – Slow Down to Speed Up

• 1000+ person employed medical group and affiliated network, under significant pressure from CEO to “move from volume to value”

• Assessed their “readiness” to generate savings (e.g., readmissions, ED, Rx, post-acute, etc.); which only amounted to only $500-600/physician

• Decided to “slow down to speed up” in its quest from “volume to value”

• Instead, engaged core group of physicians in significant “care model redesign blueprint exercise” for populations payers indicated were in most need of “management”

• Subsequently entered into MSSP and variety of commercial ACOs with a multi-payer operating model and ~300 core physicians capable of sustainable cross-continuum quality improvements and cost savings (vs. all physicians & all populations at once)
Financial Management Best Practices for Population Health

- **Budgeting process best practice**
  - Is the Population Health initiative a cost center, revenue center or profit center?
  - What comprises the Population Health’s revenue line over time? Expense items?
  - Will population health-related capital investments be given “higher priority” during start-up phase?

- **Ongoing monthly operating review best practice**
  - What’s in your CMO’s job description and KPIs?
    - Design & deployment of a cross-continuum care model that specifies people, process & technologies required to manage to a lower cost, higher quality outcome
  - What’s in your Medical Group leader’s job description and KPIs?
    - Medical group operational excellence (i.e., staffing, productivity, compensation, procurement, etc.)
  - What’s in your CFO’s job description and KPIs?
    - Budgeting for shared savings & risk
    - Measuring success and fixing problems
    - Allocating capital
    - Managing risk
  - What’s your managed care leader’s job description and KPIs?
    - Negotiator?
    - Analyst?
    - Product developer?
    - Population health leader?
Summary

**Act**
Revise and evolve payment model based on evaluation and discussions from payer negotiations.
Goal: payment model goes “live”

**Plan**
- Identify key principles
- Develop prototype payment model(s)

**Payment Model Development Process**

**Do**
- Simulate payment model results
  - Report performance on total cost of care hypothetical target based on actual data.
  - Continue infrastructure implementation.
  - Establish measure baselines.
  - Begin payer contract discussions

**Evaluate**
- Evaluate payment model given learning from CI implementation, operations, and reporting simulation.
- Evaluate simulation results in context of payment model principles.

Payment model will need to be re-evaluated over time.