CASE STUDY FOR BUILDING AN ACO
IN A SMALL MARKET - OPPORTUNITIES AND CHALLENGES

BEEBE HEALTHCARE AND DELMARVA HEALTH NETWORK

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Navvis Healthways
Todays Discussion

1. Beebe Healthcare, Delmarva Health Network and their Strategy
2. Delmarva Health Network - Organizational Process and Legal Structure
3. Infrastructure For Success
4. Questions and Discussion
Beebe Healthcare, Delmarva Health Network and their Strategic Plan
Beebe Sees the Case for Change

New 5-year plan adopted June 2011

- Outcomes Vision
- Focusing on Population Health; PCP Access; PCMH; Chronic Disease Mgt.
- Build Physician Alignment Structure
- Building Around 4 Key Service Lines
- Build Ambulatory Network Infrastructure
- Streamline Operations for Cost Savings and Physician Service
Physician Alignment Strategy

Physician Alignment Task Force – September 2012 through April 2013

Explored how Beebe and its physicians best work together to advance the triple aim of improved patient experience, better cost management, and care outcomes. The Task Force recommendations were to:

- Engage physicians to manage ambulatory care sensitive conditions (ACSC), manage care transitions, and slow progression of disease for employees and dependents;
- Charge Care Transformation Work Teams to develop evidence-based protocols for diabetes, chronic obstructive pulmonary disease, and CHF;
- Identify tools to enable sharing of data, monitoring performance;
- Share risk and reward for clinical and financial outcomes.
How Did We Get Here?

April 2013
Physician Alignment Task Force completes work

May 2013
MSSP opportunity identified

May 2013
Delmarva Health Network founded

December 2013
Medicare Shared Savings Program application approved

Ongoing
Care Transformation Specialists Post-Acute Care BPCI

To Come:
Beebe Employees Commercial Payors Medicaid
Clinical Integration within Reach

- Beebe Healthcare: History and Mission

- Clinical Components
  - 210 Beds; one hospital
  - Employed Medical Group; only 8 PCPs
  - Home Health
  - Service Lines: Ortho, Cardiac, Oncology, Women’s
  - Three ‘major’ outpatient campuses; 8 total sites
  - $315 Million Operating Revenue
  - 9,900 Admissions

- Geographic, Competitor and Payor Landscape
Delmarva Health Network - Organizational Process and Legal Structure
Delmarva Health Network-Legal Structure

- A new legal entity, led by physicians, for the purpose of working together with the hospital and other providers to improve care outcomes and costs.

- A legally compliant channel for reimbursing physicians for participation and sharing in the savings from improved clinical and financial performance.

- The “inner workings” of an accountable care organization (ACO) that can contract with Medicare, commercial managed care plans and others to capture new revenue.

The Network includes both independent and employed physicians, and primary care and specialists.
Who Governs the Network?

**Delmarva Health Network**

**BOARD OF MANAGERS**
(Physician Led with PCPs, Specialist, Medicare Beneficiary, and hospital management)

- Physician Quality Improvement Committee
- Finance Committee

**Participation Agreements**
- Primary Care Physicians
- Specialists
- Hospitals
- Post-Acute Care

**Payer Contracts**
- MSSP
- Beebe
- Payers
- BPCI
DHN Organizing Process

- Organizing Committee (PCPs)
- Develop Vision, Legal Structure, Governance, Compensation & Care Model
- Leadership Development – Coaching and Team Building
- Educate and Build the Network – Approximately 30 PCPs in Multiple Practices
- Four Months to MSSP Filing
- Transformation into DHN Board of Managers
MSSP Regulatory Issues

- Governance
- Fraud and Abuse Waivers
- Antitrust Waivers
- CMS Reporting
- HIPAA Compliance
- Beneficiary Freedom of Choice
Finance & Compensation

- Pay for Participation
- Pay for Performance
- Shared Savings
- Financial Commitment
Pay for Participation / Pay for Performance

- Pay for Participation
  - Letter Agreement
  - Scope of services on Board and Committees
  - $100/hour
  - Confidentiality

- Pay for Performance
  - Beebe Funded
  - Maximum $12,500 per physician per year
  - Focus on MSSP quality measures
## Pay for Performance

### Work Effort Payment

Aggregate work effort across all cohorts. The patient does not need to be at clinical goal for work effort to be complete.

| ≤ 50% | $2 per data element |
| > 50% | $3 per data element |

### Clinical Performance Thresholds

<table>
<thead>
<tr>
<th>1. Diabetes Composite</th>
<th>Percentage of CDC patients at goal for the following composite measure:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Diabetes A1c &gt; 9</td>
<td>Percentage of patients aged 18 through 75 years with diabetes mellitus who had most recent hemoglobin A1c greater than 9.0%</td>
</tr>
</tbody>
</table>

| ≥8% of patients at goal for HbA1c (< 8.0%) and LDL (< 100 mg/dl) and BP (< 140/90) and Tobacco non-user and Aspirin use | Payment based on % pts at goal |
| ≥18% of patients at goal for HbA1c (< 8.0%) and LDL (< 100 mg/dl) and BP (< 140/90) and Tobacco non-user and Aspirin use | $27/patient at goal |

<table>
<thead>
<tr>
<th>2. IVD LDL</th>
<th>Percentage of IVD patients at goal for the following measure:</th>
</tr>
</thead>
<tbody>
<tr>
<td>≥50% of patients at goal for LDL (&lt;100mg/dl)</td>
<td>Payment based on % pts at goal</td>
</tr>
</tbody>
</table>

| ≥30% of patients at goal for LDL (<100mg/dl) | $13/patient at goal |
| ≥50% of patients at goal for LDL (<100mg/dl) | $17/patient at goal |

### Pay for Performance

<table>
<thead>
<tr>
<th>Measure</th>
<th>Percentage of Patients at Goal</th>
<th>Payment Based on % Pts at Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>4. IVD Aspirin</strong></td>
<td>Use of aspirin or other anti-thrombotic, or documented acceptable contraindication</td>
<td></td>
</tr>
<tr>
<td>40% of patients with IVD on Aspirin or other anti-thrombotic</td>
<td>$5/patient at goal</td>
<td></td>
</tr>
<tr>
<td>60% of patients with IVD on Aspirin or other anti-thrombotic</td>
<td>$8/patient at goal</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Measure</th>
<th>Percentage of Patients at Goal</th>
<th>Payment Based on % Pts at Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>5. CHF</strong></td>
<td>Use of beta blocker, or documented acceptable contraindication</td>
<td></td>
</tr>
<tr>
<td>40% of patients with CHF on beta blocker</td>
<td>$5/patient at goal</td>
<td></td>
</tr>
<tr>
<td>60% of patients with CHF on beta blocker</td>
<td>$8/patient at goal</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Measure</th>
<th>Percentage of Patients at Goal</th>
<th>Payment Based on % Pts at Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>6. CAD</strong></td>
<td>Lipid Lowering Agent</td>
<td></td>
</tr>
<tr>
<td>40% of patients with CAD on ACE/ARB</td>
<td>$5/patient at goal</td>
<td></td>
</tr>
<tr>
<td>60% of patients with CAD on ACE/ARB</td>
<td>$8/patient at goal</td>
<td></td>
</tr>
</tbody>
</table>

Note: This measure applies to the identified patients ≥18 years of age at the beginning of the measurement period. The following data are reported for identified patients within the time period evaluated.
Shared Savings Distribution

- Defined period for repayment of capital investment
- Interest accrues starting after defined initial period
- Balance repayment with payment of meaningful physician incentives to achieve desired quality and cost outcomes

CMS/Payor

- CMS/Payor Retains
- DHN Shared Savings Pool (SSP)

DHN Operating/Capital/Loan Repayment Pool (30% of SSP)

Funds Available For Distribution

- Facilities Savings Pool (30% of SSP)
- Physician Savings Pool (40% of SSP)
Shared Savings Distribution

Allocation of Physician Pool-Performance Weighted Membership Methodology

<table>
<thead>
<tr>
<th>Practice</th>
<th>Members</th>
<th>Performance Score</th>
<th>Performance Weighted Membership</th>
<th>Percent of Performance Weighted Membership</th>
<th>Distribution to Each Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice A</td>
<td>1000</td>
<td>0.8</td>
<td>800</td>
<td>44.4%</td>
<td>$44,444</td>
</tr>
<tr>
<td>Practice B</td>
<td>1000</td>
<td>0.6</td>
<td>600</td>
<td>33.3%</td>
<td>$33,333</td>
</tr>
<tr>
<td>Practice C</td>
<td>500</td>
<td>0.8</td>
<td>400</td>
<td>22.2%</td>
<td>$22,222</td>
</tr>
<tr>
<td></td>
<td>2500</td>
<td></td>
<td>1800</td>
<td></td>
<td>$100,000</td>
</tr>
</tbody>
</table>

There are equal and symmetric effects of performance score and panel size:

- **Performance Score Impact:**
  - Practice A & Practice B have the same panel size (1000 patients), however, Practice B earns 60% of total performance score where Practice A earned 80%. This resulted in a payout of 25% less to Practice B.

- **Panel Size Impact**
  - Practice A & Practice C have the same performance score. Practice C has ½ the patient panel of Practice A thus resulting in ½ the payout to Practice C.
# Financial Commitment

<table>
<thead>
<tr>
<th>Required Investments</th>
<th>Expected Return</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Start-Up</strong></td>
<td><strong>Strategic</strong></td>
</tr>
<tr>
<td>$20,000 Capital, $172,000 Operating Expense</td>
<td>Strategic alignment with physicians enables better outcomes, costs, experience to prepare for pay for value</td>
</tr>
<tr>
<td><strong>2014</strong></td>
<td><strong>Network</strong></td>
</tr>
<tr>
<td>Operating Expenses of $519,655 and Performance Incentives of $143,750</td>
<td>Network provides effective platform to compete with regional brands for physician engagement and business</td>
</tr>
<tr>
<td><strong>2015</strong></td>
<td><strong>Financial</strong></td>
</tr>
<tr>
<td>Operating Expenses of $1,186,186 and Performance Incentives of $331,250</td>
<td>DIN share of Medicare Shared Savings (less impact of Beebe inpatient volume reduction) projected at $281K for June 2014; $649k for June 2015, and $1,077k for June 2016</td>
</tr>
<tr>
<td><strong>2016</strong></td>
<td><strong>One-Time</strong></td>
</tr>
<tr>
<td>Operating Expenses of $1,414,962 and Performance Incentives of $406,250</td>
<td>Savings from employee health plan (estimated $2.5 MM annually) from reduced utilizations and lower direct cost; 33% if which is shared with DIN</td>
</tr>
<tr>
<td><strong>Ongoing</strong></td>
<td><strong>Recoupment</strong></td>
</tr>
<tr>
<td>Dependent on expansion of value based contracting to other payers and employers (Note IP Volume impact)</td>
<td>Recoupment of Performance Incentive advances (2014 – 2016) through future shared savings (MSSP, employees)</td>
</tr>
</tbody>
</table>

- **First to Market**
  - Aligned Physicians
- **Improved Care & Lower Cost**
- **Supports the Brand Position**
- **Commercial Opportunities**
- **Proactive not Reactive Strategy**
Specialist Integration - Structure

Delmarva Health Network LLC
Board of Managers

Delmarva Orthopaedic Network
Governing Council

Quality Committee
Operations Committee
Finance Committee
Specialist Integration - Governance

- Delmarva Orthopaedic Network Council - Delegated Authority Over:
  - Service line strategy development
  - Annual operating and manpower plans
  - Care model development
  - Outcomes and cost management
  - Organizational leadership
  - Participation in Pay for Performance Contracts
  - Medicare BPCI
Leadership

- Be Selective Recruiting Physicians
- Provide Training and Education
- Take Time for Formation and Group Dynamics
- Vision, Purpose and Guiding Principles First
- Unite Around Quality and Patient Outcomes
- Meaningful Ownership Requires Giving Up Control
- (Volunteer) Leaders Require Staff Support
Protecting Your Innovation

- Acute Care Urgency May Derail You
- May be a Threat to Inpatient & Case Management
- “New” Thinking May Not Thrive in “Old” System
- Organize Outside of Traditional Patient Care Administration
- Hire from Outside Traditional Healthcare
- Create a Sense of Independence
## Foundational Elements: BeebeCARES

<table>
<thead>
<tr>
<th></th>
<th>Pre-CAREs Intervention</th>
<th>During CAREs Intervention</th>
<th>Percent Change</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average # of Readmissions</td>
<td>0.85</td>
<td>0.59</td>
<td>(30%)</td>
<td>P&lt; .001</td>
</tr>
<tr>
<td>(Intervention Group)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average # of Readmissions</td>
<td>0.82</td>
<td>0.94</td>
<td>15%</td>
<td>P&lt; .001</td>
</tr>
<tr>
<td>(Control Group)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average Cost of Care</td>
<td>$40,361</td>
<td>$28,085</td>
<td>(31%)</td>
<td>p&lt; .001</td>
</tr>
<tr>
<td>(Intervention Group)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transition Skills (Average</td>
<td>6.42</td>
<td>23.21</td>
<td>362%</td>
<td>P&lt; .00001</td>
</tr>
<tr>
<td>score per participant)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality of Life Score</td>
<td>47.69</td>
<td>20.77</td>
<td>230%</td>
<td>P&lt; .00001</td>
</tr>
<tr>
<td>(Average ‘bad’ days per</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>participant)</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

- Re-admission rate calculated using quarterly rate and averaged for both intervention and control group
- Control group represents cohort of patients with same number of readmissions and average length of stay over same time frame as CAREs Intervention group participants
- Transition Skills and Quality of Life measured among study participants immediately preceding CAREs and at discharge (90 days)
- Transitions Skills measured using the Coleman CTM-15; Quality of Life measured using the CDC Health-related Quality of Life Measure (N-HANES/BRFSS)
Foundational Elements: Post-Acute

- Nationwide, 4 of every 10 Medicare patients are discharged to a PAC setting.
- Significant variation in the quality and efficiency of PAC providers -- responsible for 40% of the variation in Medicare spend.
- Most significant reason for readmissions is lack of care coordination.

Post Acute Care Network:
- High-quality, contractually aligned Network to reduce episode cost and improve patient outcomes.
- Network participants preferred providers.
- Work collaboratively to improve care through standardized Care Plans and reduce length of stay and readmissions.

Institute of Medicine. Interim report of the Committee on Geographic Variation in Health Care Spending and Promotion of High-Value Health Care: preliminary committee observations, March 2013
Population Management Tools

- Risk Stratify Your Population
- Care Coordination Work Flow
- Report on Quality, Utilization and Cost
  - By Network
  - By Patient Population
  - By Practice
  - By Physician
- Expect a Bumpy Road Aggregating Data
Mind Your Business Model

- Sustain Ourselves Through Payer Contracts
- Rely Selectively on Others to Create Value
- Manage Our Caring: Use a Dyad of Clinical Care and Administration
- Organize to Support Our Physician Practices
Questions and Discussion