Strategies for Physician Groups to Prepare for MACRA Implementation

Tuesday – November 29, 2016
Noon – 1:00 Pacific / 1:00 – 2:00 Mountain / 2:00 – 3:00 Central / 3:00-4:00 PM Eastern

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Physician & Ambulatory Network Services
Northwell Health

Timothy Ferris, MD, MPH
SVP, Population Health Management, MGH, MGPO and Partners HealthCare
Introductions

Sharon Joy
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Agenda

• Overview of health systems
• Evaluating MIPS verses Advanced APM
• Impact of value based payments on physicians and care delivery
• MACRA’s impact on future of healthcare industry
Key Facts

...The first and largest integrated health system in NY State

- 21 hospitals
- 4 Nursing/Sub-acute facilities
- 500 ambulatory locations
- 14,000 affiliated physicians
- 3,100 employed physicians
- 7 Counties - 10.8 million population
- Provide care to 4 million persons
- 27% inpatient share
- $11 billion revenue
- Insurance Co. > 100,000 members
- 62,000 employees
- Largest private employer in NYS
- Major academic & research center
- Continuously growing footprint
- Comprehensive and full continuum of care
Northwell Health Physician Network

Clinical Integration IPA (CIIPA)
8,078 physicians

Premium Network
5,602 physicians

Employed Physicians
3,139 physicians
Background on Partners HealthCare (PHS)

• Founded by Mass General Hospital and Brigham and Women’s Hospital, PHS also includes:
  • Community and specialty hospitals
  • Managed care organization
  • Community health centers
  • Physician network
  • Home health and long-term care services

PHS by the Numbers

• 1.5M patients served annually
• 6,500 physicians
• 9,100 nurses
• 64,000 employees
• $10.9B in revenue

• In 2012, we entered new commercial and Medicare contracts that put us at risk for medical expense trend

• PHS currently has over 500,000 lives under accountable care contacts
Northwell Health Value-Based Contracting

For 2016, Northwell Health has a full range of Commercial, Medicare and Medicaid risk contracts covering close to 400,000 patients

- **Types of Programs**
  - DSRIP
  - Health Home
  - Independence at Home
  - Pay for Performance
  - Shared Savings
  - Full Risk
Northwell Health Solutions
Care Management Capabilities

- Accountable Care Analytics
data analysis, predictive modeling, risk stratification

- Remote/Telephone Care Management
24/7 clinical call center staffed by RNs

- Transitions of Care
post discharge navigation services (Ortho, COPD, AMI)

- Disease Specific Bundles
disease management, venue of care

- Complex Care Management
health risk assessment, individual care plans

- Advanced Illness Management
Home based primary care

2017 Budget:
Revenue = $22 million
Expense = $30 million

Comprised of 216 FTEs
-- including MDs, NPs, Case Managers (RN/CSW), Care Coordinators and Data Analysts
Early Performance in Care Management Programs

CMS Independence at Home (IAH) Program — Advanced Illness
- 17.4% ($6,816 PMPY) reduction in total cost for CMS Independence at Home Program – second highest performing practice in the nation
- 6 of 6 Quality Measures met

Bundled Payments for Care Improvement (BPCI)
- Decrease in readmission rates from 7% to 6% in Orthopedics, 24% to 15% in Cardiac Surgery
- Increase in Discharge to Home from 43% to 65% in Orthopedics
- Positive financial performance in BPCI program

Comprehensive Care for Joint Replacement (CCJR)
- 69% of patients received a Medication Reconciliation within 72 hours of discharge
- Increase in Discharge to Home from 13% to 43.2%

Complex Care Management*
- 8% reduction in total cost of care
- 24% reduction in inpatient spend
- 18% reduction in admissions per thousand
- 16% reduction in ED visits per thousand

Transitional Care Management**
- 74% Engagement rate post-discharge
- 30-Day Readmission rate <5% in engaged patients

<table>
<thead>
<tr>
<th>Year</th>
<th>BPCI Orthopedic Surgery Bundles</th>
<th>BPCI CT Surgery Bundles</th>
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<tbody>
<tr>
<td></td>
<td>Readmission Rate</td>
<td>Home Discharge %</td>
</tr>
<tr>
<td>2014</td>
<td>7%</td>
<td>43%</td>
</tr>
<tr>
<td>2015</td>
<td>5%</td>
<td>50%</td>
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<tr>
<td>2016 (August)</td>
<td>6%</td>
<td>65%</td>
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The path we’re traveling at Partners

Pressure to reduce cost trend

New contracts with risk for trend

Changes to Partners organization structure

Investment in Population Management Infrastructure

- Primary Care
- Specialty Care
- Care Continuum
- Patient Engagement
- IS/Analytics

Internal Performance Framework (IPF)

- Implement new local incentives/compensation

Network Composition

- New relationships with community hospitals and doctors

Improved quality and lower cost trend
How the Internal Performance Framework (IPF) works

- We determine the content, not payers
- Renewed annually
- Shared goals, but RSOs can choose different paths
- Forfeited funds pay external contract losses
Quality Payment Program

- QPP
  - MIPS
    - Advanced MIPS
  - APMs
    - Advanced APMs
    - Non-Advanced APMs

- Quality (50%)
- Advancing Care Information (ACI) (30%)
- Clinical Practice Improvement Activities (CPIA) (20%)
- Resource Use (0%)
Medicare Shared Savings Plan – Track 1

MIPS / MSSP Track 1

- Quality, 50%
- ACI, 30%
- IA, 20%

MSSP GPRO measures satisfy 100%. Calculated at ACO Level

Report at ACO Level
Weighted average of All TINS in ACO
If Protected Health Information is not achieved, entire ACO score is 0

Get full points by being in MSSP Year 1
All Billing TINS with at least one PCMH site automatically receive 100% eligible points
Organizational Impact

• Physician Alignment Activities: AEHR optimization; MACRA checklist; chart abstraction
• Physician Education: town halls, newsletters, physician portal
• Integrated Scorecards for quality, patient experience, operational and financial metrics
• Interdisciplinary committee created to monitor performance and make recommendation for MIPS vs Advanced APM for 2018.
“Perfection is not attainable but if we chase perfection we can catch excellence”

- Vince Lombardi
POPULATION HEALTH AT PARTNERS HEALTHCARE

System

- Partners HealthCare
  - Primary Care
  - Acute Hospital and Post Acute
  - Specialty Care

Goals

- Increased Patient Satisfaction
- Measurably Improved Healthcare
- Decreased Costs
- Increased Provider Satisfaction
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Goals

- Quadruple Aim
  - Increased Patient Satisfaction
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**System**
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**Trend Drivers**
- Expenses concentrated in a small percent of high-need patients with multiple chronic conditions
- Behavioral and mental health problems increase costs of patients with chronic illness 3-5x
- Patients seek emergency room care due to lack of alternatives
- Multiple specialty and primary providers at different sites is inefficient
- High use of post-acute care in the northeastern US
- Patients at end of life often experience uncoordinated care inconsistent with their wishes
- Patients receiving care across multiple health systems results in redundancy
- Goals are set by healthcare providers rather than by clinical outcomes that matter to patients
- Specialty visits and services are a large fraction of healthcare costs
- Large variation in visit, test, and procedure rates among specialists

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**Quadruple Aim**
POPULATION HEALTH AT PARTNERS HEALTHCARE

**System**
- Primary Care
  - Patient Centered Medical Home
  - Behavioral Health Integration
  - High Risk Care Management
  - Skilled Nursing Facility Strategy
  - Palliative Care
  - Home Care Innovation
  - Heart Failure Telemonitoring
  - Virtual Visits
  - Patient Engagement
  - Collaborative Care Agreements
  - E-Consults
  - Procedure Decision Support
  - Bundles
  - PROMs
  - Patient Education Materials

**Outcomes Measures**
- Decrease Unnecessary Utilization
  - Primary Care Visits
  - Specialty Care Visits
  - Procedures
  - Emergency Department Visits
  - Hospital Admissions
- Continuous Coordinated Care
  - Personalized Care Plans
  - PCP-Specialist Communication
  - Transitions
  - Appropriate Post-DC Services
- Access to High Value Care
  - Primary Care Urgent Visits
  - Consultation with Specialists
  - Mental Health Resources
  - Appropriate Post-Acute Care
  - Medication Adherence
  - Preventive Care
- Patient Centered Care
  - Home-Based Care
  - Goals of Care Discussions
  - Health Literacy
  - Facilitate Highest Functional Gain
  - Less Depression, Substance Use

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**Quadraple Aim**
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- Acute Hospital and Post Acute

- Specialty Care

Programs

Outcome Measures

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Quadra P Aim
Question and Answer

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To Complete the Program Evaluation

The URL below will take you to HFMA on-line evaluation form. You will need to enter your member I.D. # (can be found in your confirmation email when you registered)

Enter this Meeting Code: 16AT61

URL: http://www.hfma.org/awc/evaluation.htm

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