Shared Accountability: Intermountain's Reform Strategy

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Objectives:
- Define Redesigning care. Intermountain uses evidence-based medicine—treatments and procedures that have been proven effective—to deliver the right care, in the right setting, at the right time. We avoid under-treatment, over-treatment, and the misuse of resources.
- Describe Realigning financial incentives. Intermountain is changing incentives by reducing the incentives to provide more volume of care and adding incentives to provide high quality and service. We also continue our traditional focus on efficiency, which helps us keep costs low.
- Explain Engaging patients. We achieve better health for those we serve by promoting wellness and prevention. We help patients become more engaged in their health and in choices about their care.
Shared Accountability & Population Health Management

Carter Dredge
Director of Healthcare Transformation

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Agenda

• Shared Accountability – Three Focus Areas

• Population Health Management (PHM)
  • A Strategy / Approach
  • An Operational Model

• Physician Payment

• How Will Things Be Different (e.g. CCM Pilot)

• Putting It All Together
  • “Building the Bridge”
Redesigning Care

Shared Accountability

Aligning Financial Incentives

Engaging Patients and Members

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Understanding Total Cost of Care

Uses of SelectHealth premium

Population Health Budget

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Getting to CPI+1%

Intermountain Healthcare
Patient Services
Net Revenue in Millions

Historical Revenue Growth Trend
Lower Revenue Rate Increases
Manage Utilization

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Components of Cost

Healthcare Cost Per Person = \[ \text{Population Utilization} \times \text{Intracase Utilization} \times \text{Health Episodes Per Person} \]

Days, MRIs, Lab Tests

Intracase Utilization

Population Utilization

How much we use
Value improvement benefits flow exclusively to payers

Payment model rewards focus on acute, episodic care

Payment model rewards providers for higher value care

Unmanageable risk for providers

Population Needs-Based Care Management, Evidence Based Prevention and Wellness
- CDS, Continuum of Care Analytics, Transition Management, Predictive Modeling
- Registries, Basic Care Management, Population Analytics, EBM Protocols
- Limited Capability

Independent Physicians and Hospitals - FFS

Care Coordination Fees - PCMH

Bundled Case Rates

Population-Based Risk Contracts

Payment Evolution

Insurance Company Bears Financial Risk for a Population

Health System Bears Financial Risk for a Population
Seeing a Lot of Variability Along the Way

Clear Differences in Providers’ Ultimate Destinations

Projected Revenue Breakdown in 10 Years, by Provider Identity

n=76

Volume-Oriented Providers (26%)
- Total Cost of Care: 49%
- Bundled Payment: 38%
- Pay for Performance: 10%
- Fee for Service: 9%

Destination Care Providers (27%)
- Total Cost of Care: 12%
- Bundled Payment: 41%
- Pay for Performance: 9%
- Fee for Service: 10%

Population Health Managers (19%)
- Total Cost of Care: 8%
- Bundled Payment: 23%
- Pay for Performance: 60%
- Fee for Service: 20%

Living in Two Worlds (30%)
- Total Cost of Care: 43%
- Bundled Payment: 27%
- Pay for Performance: 10%
- Fee for Service: 20%

Source: 2013 Accountable Payment Survey; Financial Leadership Council interviews and analysis.
In Summary…

Intermountain’s strategy is to move to population health management to improve health outcomes while ensuring long-term cost sustainability.

- Manage full spectrum of our member’s health
- Remain financially stable by accepting risk for a population and appropriately managing healthcare expenditures for that population (i.e. TCOC)
- Provide evidence-based high value care
- Engaging with physicians and patients in new ways
PHM – An Operating Model

- Provides Care Process Models
- Distributes budgets
- Provides Population Health Mgt. Services

Payer

“Population Budget”

Intermountain Healthcare

Regional Virtual Network

Intermountain Hospitals

Intermountain employed Physicians

Contracted affiliated Physicians

Other facilities and providers

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PHM Analytics Capabilities

EDW Data Marts

- Claims Based Cost of Care Data
- Claims Based Quality Measures
- Intermountain Clinical Data
- Patient Experience Data
- Risk Stratification Data
- Admit, Discharge, & Transfer Data

Web-based Reporting Platform

End Users

- Physicians
- Care Managers
- Administrators

Patient-level detail
Condition-level detail
Procedure-level detail
PHM Analytics - A First Look
Physician Payment Beta – Objectives

1. Engage physicians, both employed and affiliated, in a learning experience

2. Demonstrate that we can operationalize the model
   a. Implement a process to create and measure quality, service, and total cost of care
   b. Implement a scalable payment mechanism
   c. Implement a reporting process

3. Gain physician support to continue forward
Payment Model Components
Paid at the Group Level

<table>
<thead>
<tr>
<th>Productivity</th>
<th>Service</th>
<th>Quality</th>
<th>Total Cost of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>75% Productivity</td>
<td>6.25%</td>
<td>6.25%</td>
<td>+/- 12.5%</td>
</tr>
<tr>
<td>75% Productivity</td>
<td>8.75%</td>
<td>8.75%</td>
<td>+/- 12.5%</td>
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</table>

Between Target and Stretch:
- 75% Productivity

Above Stretch:
- 75% Productivity
Community Care Management (CCM) Pilot

What is it?
- New Care Management Pilot
- Operates under a PHM incentive structure

Which patients will it serve?
- **Two Points of Entry:**
  1. **Highest cost and most complex patients***
  2. **Concurrent referrals** from other care managers or clinicians

- **Additional Information:**
  - **Includes** patients with mental illness**
  - **Excludes** certain conditions (e.g. solid organ transplant patients, burns, etc.); and pediatric patients <18 years old

*Approx. 400 patients; $15 MM in hospital and home care payment (i.e. cost to purchaser)
** 40% of the Top 400 had at least 1 mental health diagnosis in the past 3 years
Community Care Management (CCM) Pilot

Who’s on the core team?
- 1 RN Care Manager
- 1 LCSW
- 1 Health Advocate (MA)

What is the model design?
- **In-home visits** to understand environment of care
- Connects patients to both Intermountain & community-based resources
  - Primary care
  - Homeless shelters
  - Mental health
  - Food security programs
  - Home Health
  - Pharmacy
- **Frequent follow-up & support**
- Care **coordination** to navigate complexities of healthcare system
Community Care Management (CCM) Pilot

What’s the financial impact?
• Appropriate utilization (even if lower) can result in savings—with the right types of contracts

<table>
<thead>
<tr>
<th>Insurance Type</th>
<th>Variable Costs</th>
<th>Net Revenue</th>
<th>Margin Impact</th>
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</thead>
<tbody>
<tr>
<td>Aligned Contracts</td>
<td>Decrease</td>
<td>Constant</td>
<td>Positive</td>
</tr>
<tr>
<td>Non-aligned Contracts</td>
<td>Decrease</td>
<td>Decrease</td>
<td>Negative</td>
</tr>
<tr>
<td>Uninsured</td>
<td>Decrease</td>
<td>Decrease</td>
<td>Positive</td>
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</tbody>
</table>

The bottom line...
• Patients get better, more coordinated care
• Lower cost of delivery; enables reinvestment for future cost-saving efforts
• Members/community pay lower prices in the future
Shared Accountability
“Building The Bridge”
Questions?

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