Financing Integrated Social Services for the High-Need, High-Cost Patient Population

September 14, 2017

ACHIEVING VALUE THROUGH TRANSFORMATION
A Webinar Series

Speakers

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Jeff has been the Executive Director of the Task Force since 2015. He previously served as General Counsel for the Federation of American Hospitals.

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Colin LeClair is an Accountable Care Organization strategy expert. He has held executive positions at the nation's leading medical groups and health plans.

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Dr. Levine is an expert in care delivery transformation. He has served in a variety of executive roles with providers and health plans, and is an Assistant Clinical Professor at UCLA and Stanford School of Medicine.

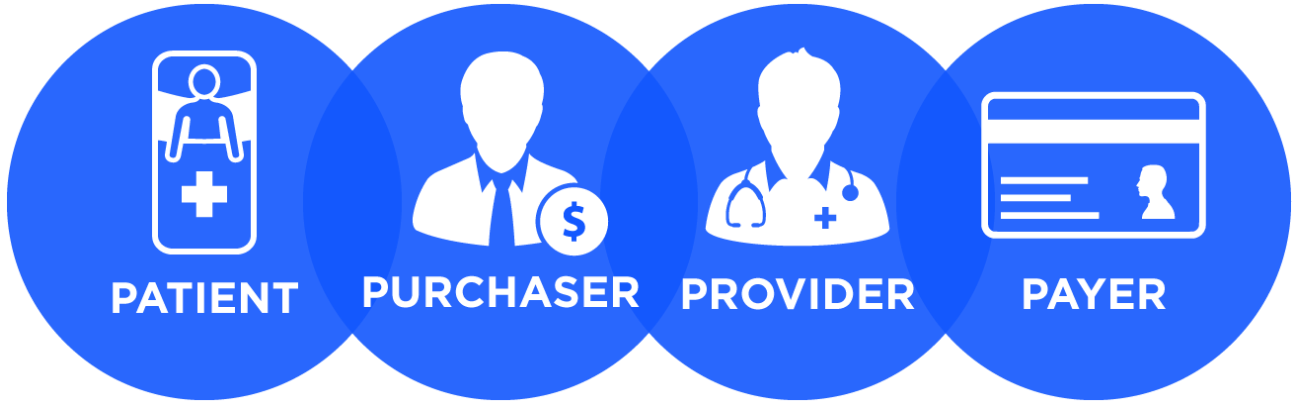
Agenda

- Introduction to the Health Care Transformation Task Force
- Overview of Social Service Integration and Financing Framework
- Case Study: ConcertoHealth
- Case Study: agilon health
- Q&A
- Upcoming Webinars

Who we are: Our mission to achieve results in value-based care

The Health Care Transformation Task Force is an industry consortium that brings together patients, payers, providers, and purchasers to align private and public sector efforts to clear the way for a sweeping transformation of the U.S. health care system. We are committed to rapid, measurable change, both for ourselves and our country.

We aspire to have 75% of our respective businesses operating under value-based payment arrangements by 2020.

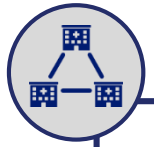


Our Members: Patients, Payers, Providers and Purchasers committed to better value

The Task Force's guiding principles outline a financially and operationally viable and sustainable approach

- **Shift 75% of our respective businesses to be under value-based care contracts by 2020**
- Design programs that provide reasonable returns to deliver the triple aim of better health, better care and reduced total cost of care at or below GDP growth
- Equip market players with all tools necessary to compete in new market focused on people-centered primary care
- Encourage multi-payer participation and alignment to create common targets, metrics, and incentives
- Share cost savings with patients, payers, and providers to ensure adequate investment in new care models
- Foster transparency of quality and cost metrics in a manner that is accessible to, and easily understood by, consumers
- Support the needs of disadvantaged populations and help strengthen the safety net providers who serve them

TF Work Groups drive rapid-cycle product development



Improve the ACO Model

Develop aligned public-private action-steps and recommendations to improve the design and implementation of the ACO model

Develop Common Bundled Payment Framework

Create detailed principles and tools to align and evaluate episode definitions/pricing for public/private payer bundled payment programs.

New Model Development - Improving Care for High-cost Patients

Create, test and recommend a delivery/payment model that allows a wide range of provider organizations, including in rural areas with little to no current MA/ACO penetration, to engage in population health by starting with highest-cost patients (top 5%).

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Understanding the high-cost patient

22% Of total spending by top 1%

90% Of total spending by top 30%

43% Of persistent spenders are 65 or older

40% Of persistent spenders between the ages of 45-64

High-cost patients can be identified by three subtypes:

Can impact with intervention

1) Patients with Advanced Illness

Often nearing end of life, and responsible for some of the highest costs. Patients often die within 1-2 years. Opportunities to provide home and community-based services that cut down on unnecessary hospitalizations.

2) Patients with Persistent High Spending Patterns

Characterized by multiple chronic conditions. Many face psychological and social barriers to care. Many are good candidates for care management/social support services.

3) Patients with Episodic High Spending

Have increased costs due to a sudden event, but costs decrease as the condition resolves. Difficult to target proactively because cost spikes are usually not predictable.

Sources: Proactively Identifying the High Cost Population. *Health Care Transformation Task Force,* 2015. NIHC Concentration of Health Care Spending. *National Institute for Health Care Management Foundation*, July 2012.

Social service integration framework

Integrate social services into broader care delivery and care management process

Identify Target Population	Identify Social Needs	Assess Community Resources	Develop Social Service Integration Model	Implement Social Integration Structure
Determine the following: • How impactable individuals will be identified • Which events and conditions have potential for highest impact from patient and system financial perspective	Identify areas of highest social service need for the designated population Resources: • *Hospital Community Health Needs Assessments* • *Behavioral Risk Factor Surveillance System*	Assess existing social service providers and capacity to meet priority social service needs: • Public agencies (federal, state, local) • Public programs • Community-based organizations	Based on available community resources and capacity to engage, determine best governance model and financing structure: • Joint Venture • Closed-loop Referral Network • Delegated Community Partnership	• Define common priorities and specific responsibilities • Adopt shared measures of success • Implement systems to coordinate • Evaluate process • Refine model

Reference methodologies: Commonwealth Fund State Policy Framework, Institute of Medicine's Community Health Improvement Process

Financing Options for Social Service Integration

Pilot	Expansion	Mature
• Small-scale federal grants • Small-scale state grants • Non-profit/philanthropic grants • System funding • Payer funding • Other?	• Dedicated state funding • Medicaid waivers • Expanded non-profit/philanthropic funding • System funding • Payer funding	• Dedicated state funding • Medicaid waivers • System funding • Payer funding

Questions

- Will the program be carved-out (standalone) or integrated into the care delivery model?
- Does the organization have a plan for long-term financing? If so, who will be the primary funders?

Reference: https://www.chcs.org/media/Medicaid_-Soc-Service-Financing_022515_2_Final.pdf

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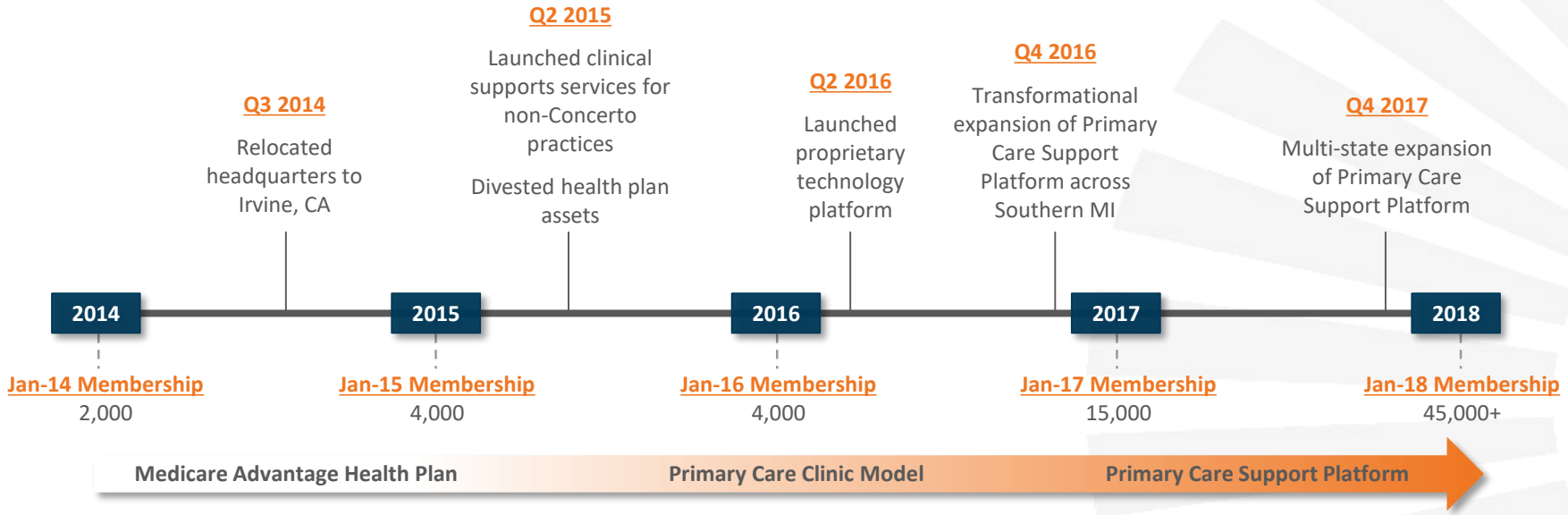
ConcertoHealth

Health Care Transformation Task Force

Social Services Integration Financing Webinar

September 14, 2017

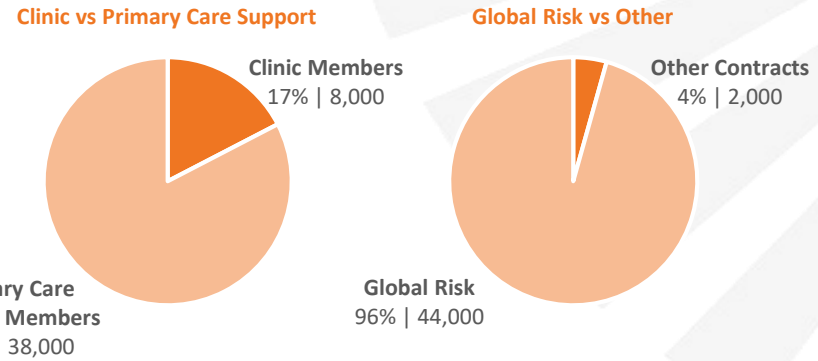
Concerto evolved out of its predecessor patient-centered medical home business to deliver primary care support services to health plan network providers and manage complex populations



Geographies

- Southern Michigan
- Greater Seattle Area
- Greater Chicago and Greater Peoria Areas
- Columbus, Cincinnati, & Toledo, Ohio
- New Mexico (statewide)

January 2018 Membership



Problem Statement: New Expectations of Payors & Providers

The Concerto care model was developed in response to health plan demand for a partner who can address all of their strategic challenges and support their overworked providers

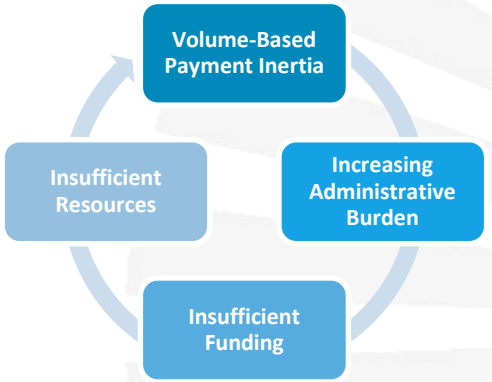
The Health Plan Challenge

"I have plenty of good primary care doctors in my network. I don't need more. What I need is for my providers to support all of our performance objectives – quality, compliance, medical cost, administration…." – Concerto Health Plan Partner CEO

1. **Value-Based Payments**
2. **Patient Engagement**
3. **Primary Care Access**
4. **Quality (STARS)**
5. **Accurate Risk Adjustment & Revenue**
6. **Medical Expense Management**
7. **Medicare Model of Care (MOC) Compliance**
8. **Diverse Populations**

The Primary Care Challenge

The Volume-Based Payment Cycle



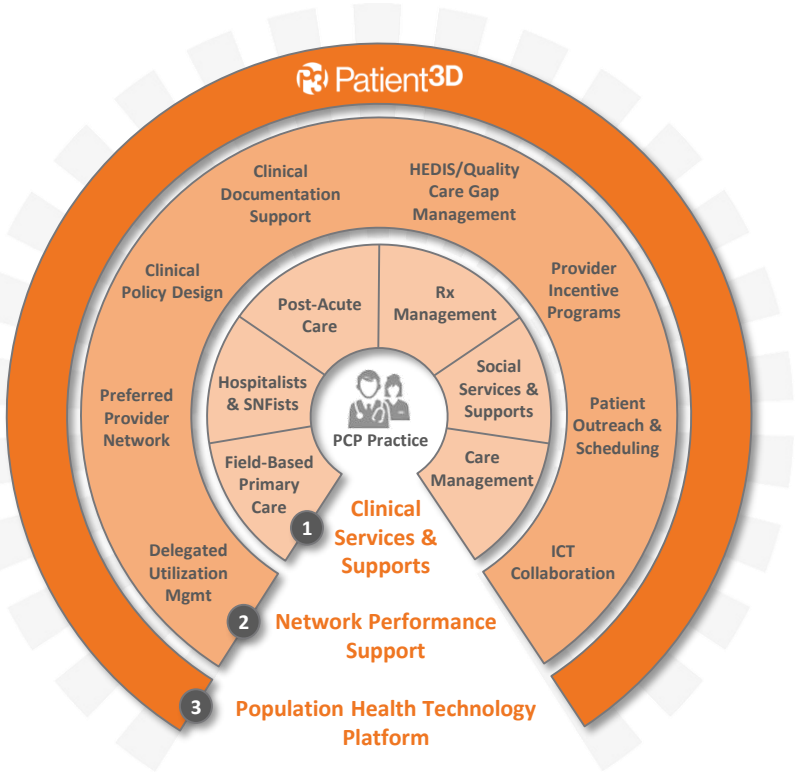
- **PCPs remain dependent on fee-for-service income**
- **Value-based care increases provider burden without first providing additional capacity**
- **Many of the most impactful clinical services are not compensable by Medicare or Medicaid**
- **Insufficient time and clinical staff to monitor the care patients receive across all settings**

A disruptive tech-enabled clinical model is required to bridge the chasm between health plan needs and current primary care capabilities

Social Services Core to ConcertoHealth Model

Concerto equips primary care providers with dedicated, "wraparound" clinical and administrative resources to enhance their ability to manage their patients in a value-based environment

ConcertoHealth Primary Care Support Platform



Scope of Services

1. **Clinical Services & Supports**
   - Risk-bearing medical group with employed physicians and nurses equipped to treat patients in any setting
   - Concerto assigns an Interdisciplinary Care Team (ICT) to each network PCP and their patients
   - ICT provides diagnostically appropriate clinical support and 24/7 patient monitoring across all settings

2. **Network Performance Support**
   - Delegated utilization management allows Concerto to accept global financial risk on behalf of network PCPs
   - Concerto collaborates with health plan partners to design and implement value-based incentive programs for network providers
   - Concerto provides network PCPs with the clinical resources, administrative support, and technologies to make them successful
   - Concerto improves healthcare quality and access by encouraging referrals to sub-networks of high-quality, cost-effective, preferred providers

3. **Population Health Technology Platform |** Patient3D
   - Provides population health analytics and medical economics dashboard
   - Provider portal with real-time patient alerts, point-of-care decision support and performance reporting/management
   - Clinical work flow optimization and compliance management

At the center of Concerto's care management team, social workers play an integral role in coordinating and integrating physical and mental health services

Role	Description	Performance Metrics
Clinical Care Management		
Case Managers	o Comprised of RNs, LPNs, LVNs and others o Telephonic or face-to-face engagement of patients with complex care needs o Periodically perform health risk assessments to determine Member's level of risk o Quarterback Member's care plan and Interdisciplinary Care Team o Pre-discharge planning, transitions of care, post-discharge coordination/assessment	- Patient contact/engagement - Current HRA - # and frequency of PCP visits - Engagement in social services and supports program - ED visits - Ambulatory sensitive condition admissions - Total acute admissions - All-cause readmission rates - Med adherence
Social Workers	o Comprised of MSWs and LCSWs o Telephonic or face-to-face engagement of socially complex, and low income patients o Periodically perform community-based supports and services assessments to facilitate patient eligibility reverification and enrollment o Management of long term supports and services for eligible populations o Key participant on Interdisciplinary Care Team	
Care Coordinators	o Primarily administrative professionals dedicated to supporting Case Managers and Social Workers to complete non-clinical tasks o Transmit/share patient medical records among treating providers o Collect patient medical records and discharge plans from hospitals/skilled nursing facilities o Validate/confirm that vendor services are provided as prescribed/referred o Perform patient outreach to schedule or confirm required services	

Concerto's staffing ratios are tailored to address the unique needs of a given patient population in a resource-constrained environment

Illustrative Concerto Staffing Ratios

Example: Concerto Case Management Staffing Ratios, Adjusted for Population Risk

Risk Level	Typical Distribution	ABD	DSNP	MMP	NFLOC/ Waiver	MAPD	Exchange	Commercial
Catastrophic/Complex	3%	206	108	108	36	240	120	150
High Risk	12%	344	180	180	60	400	300	375
Medium/Average Risk	40%	430	225	225	75	500	600	750
Low Risk	35%	602	315	315	105	750	900	1,125
Very Low Risk	10%	1,204	630	630	210	1,500	1,800	2,250

Example: Concerto Social Worker Staffing Ratios, Adjusted for Population Risk

Risk Level		ABD	DSNP	MMP	NFLOC/ Waiver	MAPD	Exchange	Commercial
Catastrophic/Complex	3%	269	128	114	75	313	720	900
High Risk	12%	538	245	234	91	1,000	1,800	2,250
Medium Risk	40%	860	450	450	113	2,000	3,600	4,500
Low Risk	35%	1,394	608	547	143	2,431	5,400	6,750
Very Low Risk	10%	2,240	852	670	180	2,976	10,800	13,500

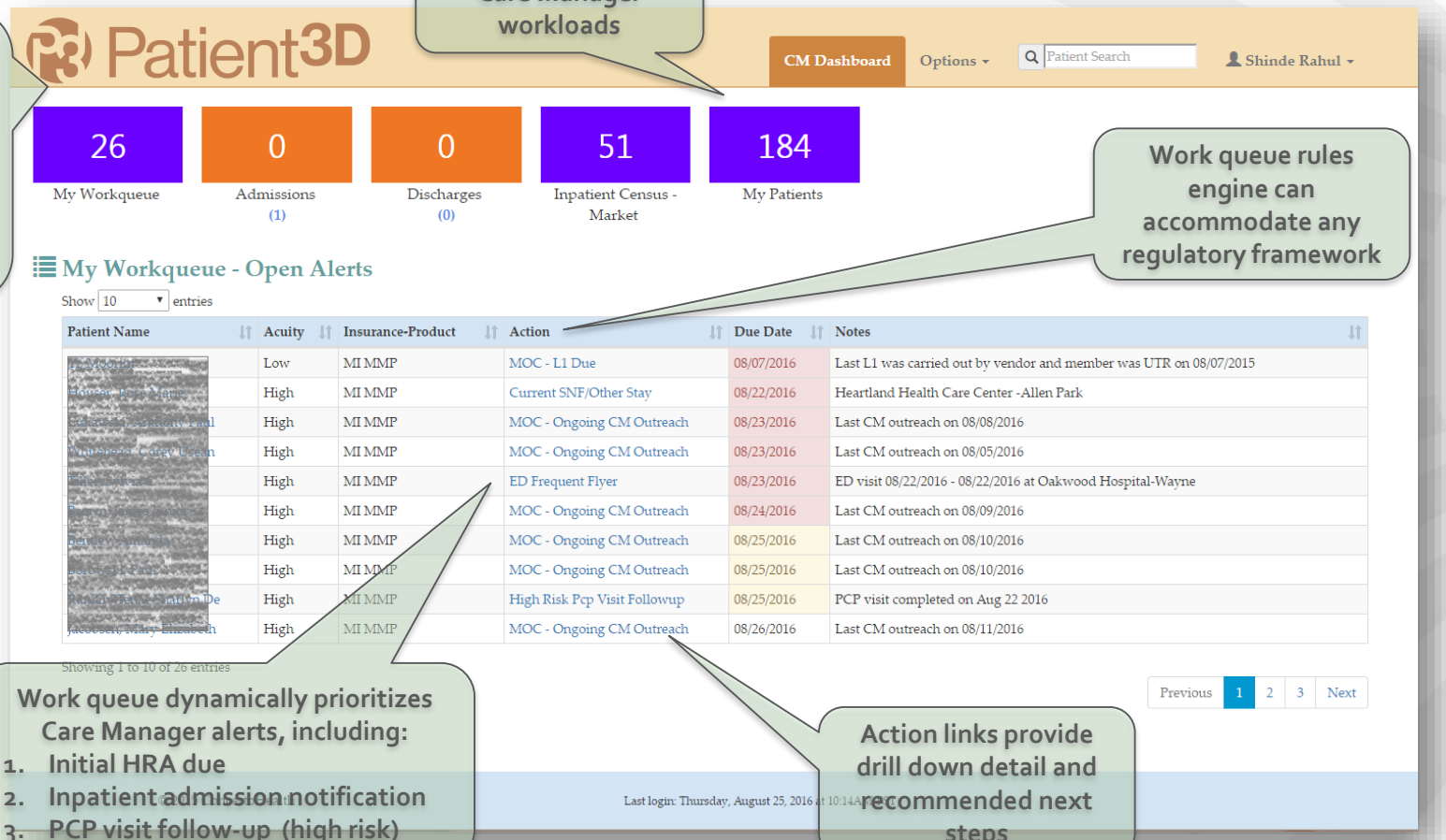
- Concerto uses medical claims, lab values, Rx encounters, and other social determinants data to risk stratify the population
- The resulting distribution informs the company's staffing model
- Staffing also varies by payor and product to accommodate unique regulatory/compliance requirements (eg. Medicare Model of Care variation)
- Staffing ratios are continuously refined and tailored to population disease prevalence, demographics, utilization patterns, and other population characteristics

Concerto's investment in Social Services & Supports ranges as much as $40pmpm for an LTSS population to as little as $4pmpm for a typical MAPD population

The Care Management Module within Concerto's Patient^{3D} solution supports real-time notification of critical patient changes and coordination across the care team

System uses real-time encounter data, upcoming compliance deadlines, and each patient's unique clinical profile

Tiles call out critical Care Manager workloads



Work queue rules engine can accommodate any regulatory framework

Work queue dynamically prioritizes Care Manager alerts, including:

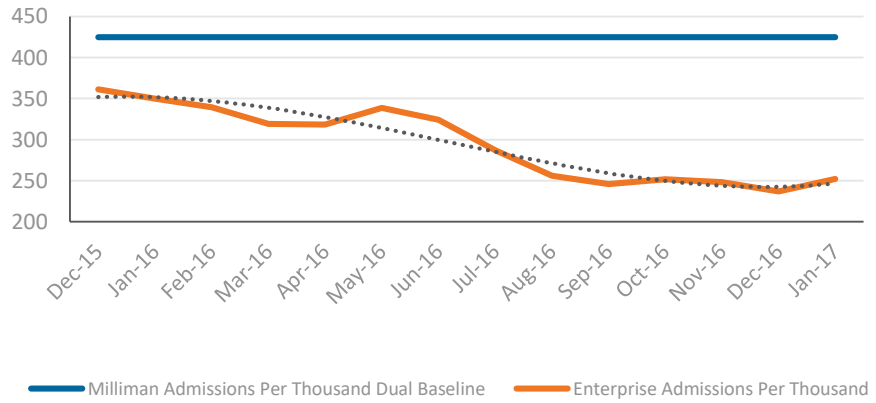
1. Initial HRA due
2. Inpatient admission notification
3. PCP visit follow-up (high risk)

Action links provide drill down detail and recommended next steps

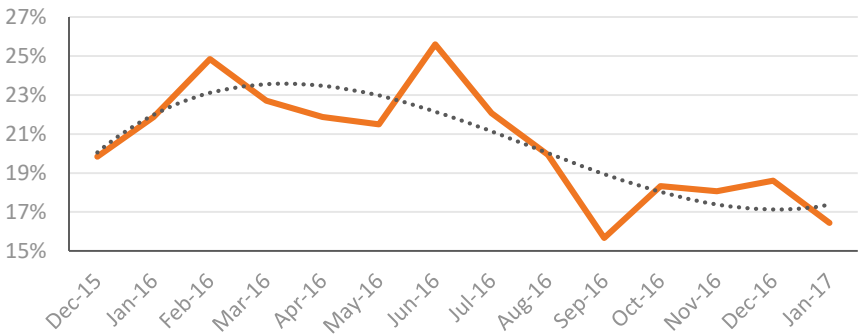
Medical Cost Performance

Consistent improvements in inpatient costs are highly correlated with improvements in patient engagement driven largely by Care Manager and Social Worker activities

2016 Admissions Per Thousand



2016 All-Cause 30-Day Readmissions



Clinical Performance Overview

Inpatient Performance

- ✓ Reduced admissions per thousand by average of 30% YOY
- ✓ Developed capability to intercept 85% of potential admissions; divert inappropriate admissions to Observation, SNF, or next-day PCP visit

Readmission & Post-Acute Performance

- ✓ Readmission rates continue to decline despite reduction in unnecessary admissions (i.e. readmission rates improved for highest risk admits)
- ✓ Over 75% of hospital discharges resulted in ambulatory care follow-up, almost 15% favorable to market average

[1]Membership added since inception of global capitation agreements

Concerto funds social services and supports by folding these activities into a broadly defined Primary Care Capitation fee, eventually transitioning to Global Risk

Common Early Stage Social Services Funding Models

1. Fee-for-Service
    - Limited compensable services (health and behavioral assessments and interventions)
    - Low reimbursement rate
    - Often inadequate patient need to justify FTE

2. ACO or “Pod” Model & Shared Savings Contract w/ Plan
    1. Supports “fractional ownership” of FTE
    2. Scheduling/sharing of resource complicated
    3. Longtime familiarity with face-to-face-only medicine hampers adoption of remote model
    4. Reimbursement inadequate
    5. ROI difficult to demonstrate across small sample to support reinvestment

ConcertoHealth Social Services Funding Models

1. Broad-Scope PCP Capitation
    - Sufficient patient volume still required to justify FTE
    - Larger cap rate typically requires some shared risk

2. Part B Capitation
    - Larger cap rate creates room for discretionary investment in social supports
    - Scope of financial responsibility requires medical management expertise and supporting analytics
    - Arrangement typically requires risk for some institutional (Part A) cost

3. Global Capitation w/ 100% Risk for Cost & Quality
    - Provides complete discretion to invest in clinical supports and services that have greatest impact
    - Ensures alignment of payor and provider incentives
    - Requires balance sheet to securitize claims risk
    - Requires scale to support actuarial soundess

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Health Care Transformation Task Force

Social Services Integration Financing Webinar

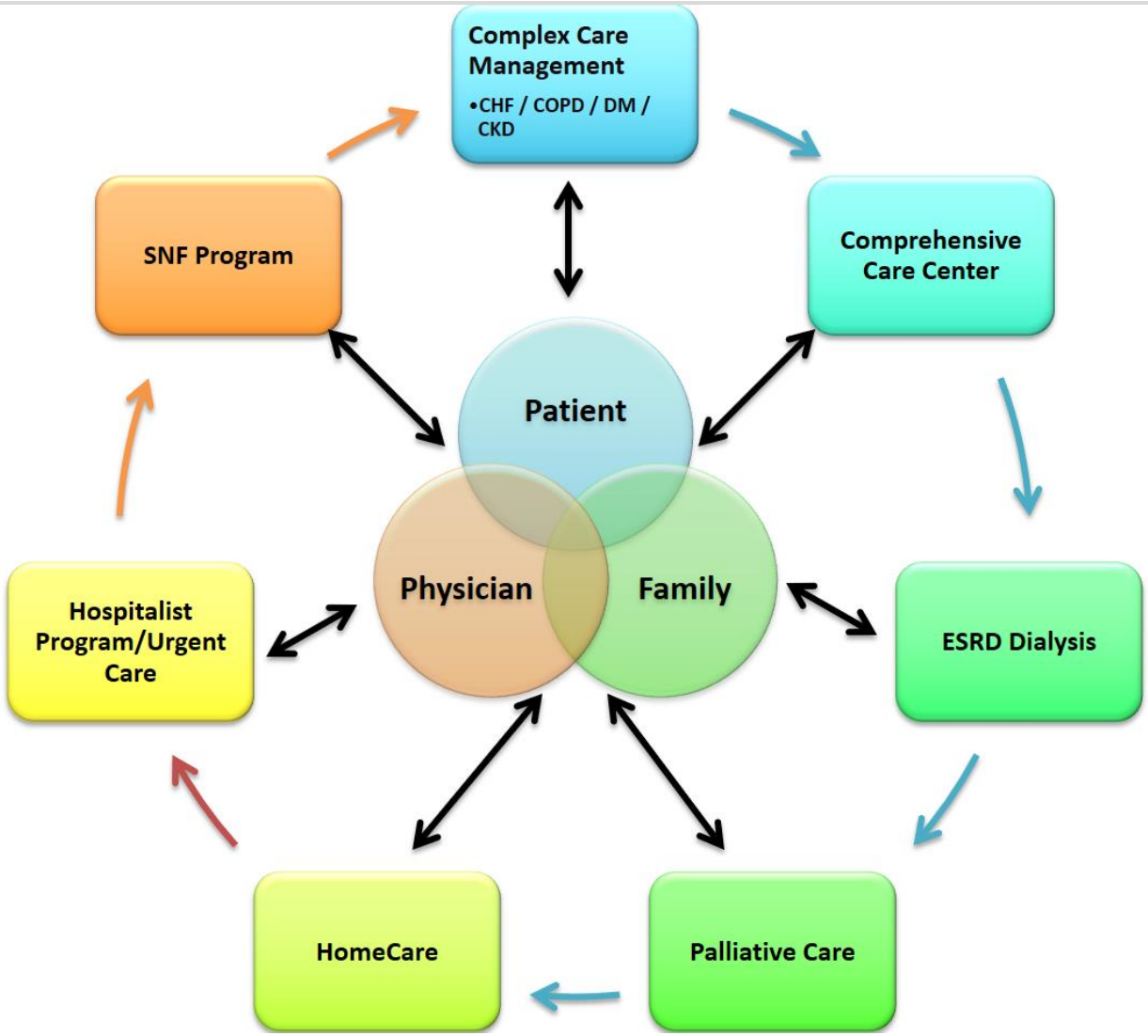
September 14, 2017

About agilon health

- Health care services and technology firm
- Partners with primary care physicians to bring people, solutions, capital and technology necessary to support transformation to fully-capitated, value-based model
- Partnerships with IPAs in six different markets across the US, including:
  - Vantage Medical Group (LA metro area)
  - First Choice Medical Group (Central Valley, CA)
  - MDX Hawai'i (HI)
  - Central Ohio Primary Care Physicians Medical Group (OH)

agilon care model

Social services are directly and indirectly woven into the care model for the programs identified here



Patient profile

Reimbursement

- 550,000 Medicaid
- 70,000 Medicare
- 10,000 Dual-Eligible
- 10,000 Commercial

Conditions

Asthma COPD CHF Cancer Chemical Dependency Chronic Pain CKD/ESRD

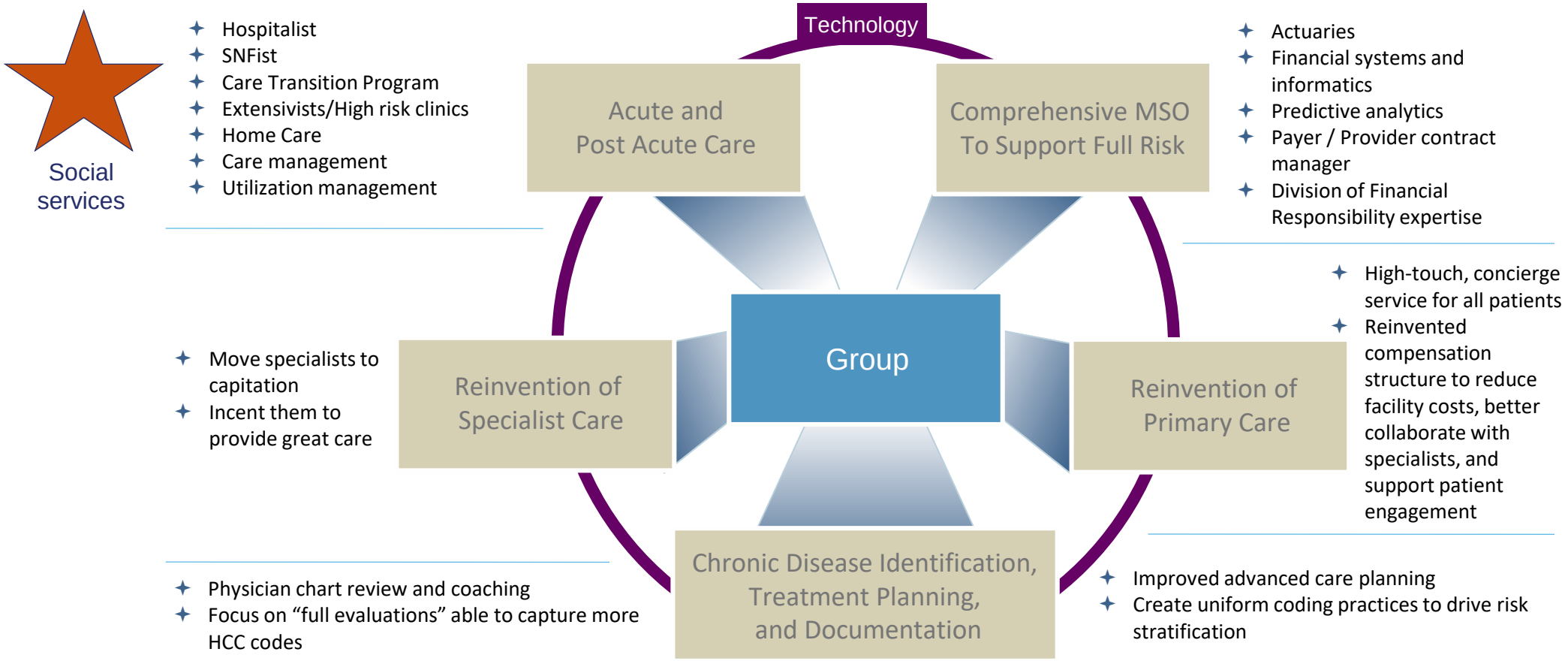
Major Depression High Risk Pregnancy Stroke

Eligibility

- 10 – 30% of patients are eligible for care management services
- 25 – 30% of patients receive social services

Migration to capitation requires an "Operating System"

Provider organizations need integrated services to migrate to a global capitation business model



…including advanced technology to support the reengineering of care processes

Patients need to be stratified into appropriate clinical programs

Hospice / Palliative Care - Home Care Management:

Provides in-home medical and palliative care management with

Specialized Physicians, Nurse Care Managers and Social Workers

Focus- chronically frail seniors that have physical, mental, social and financial limitations that limits access to outpatient care, forcing unnecessary utilization of hospitals

High Risk Clinics and Care Management

intensive one-on-one physician /nurse patient care and case management for the highest risk, most complex population. As the risk for hospitalization is reduced, patient is transferred to Level 2. Physicians and Care Managers are highly trained and closely Integrated into community resources and physician offices or clinics.

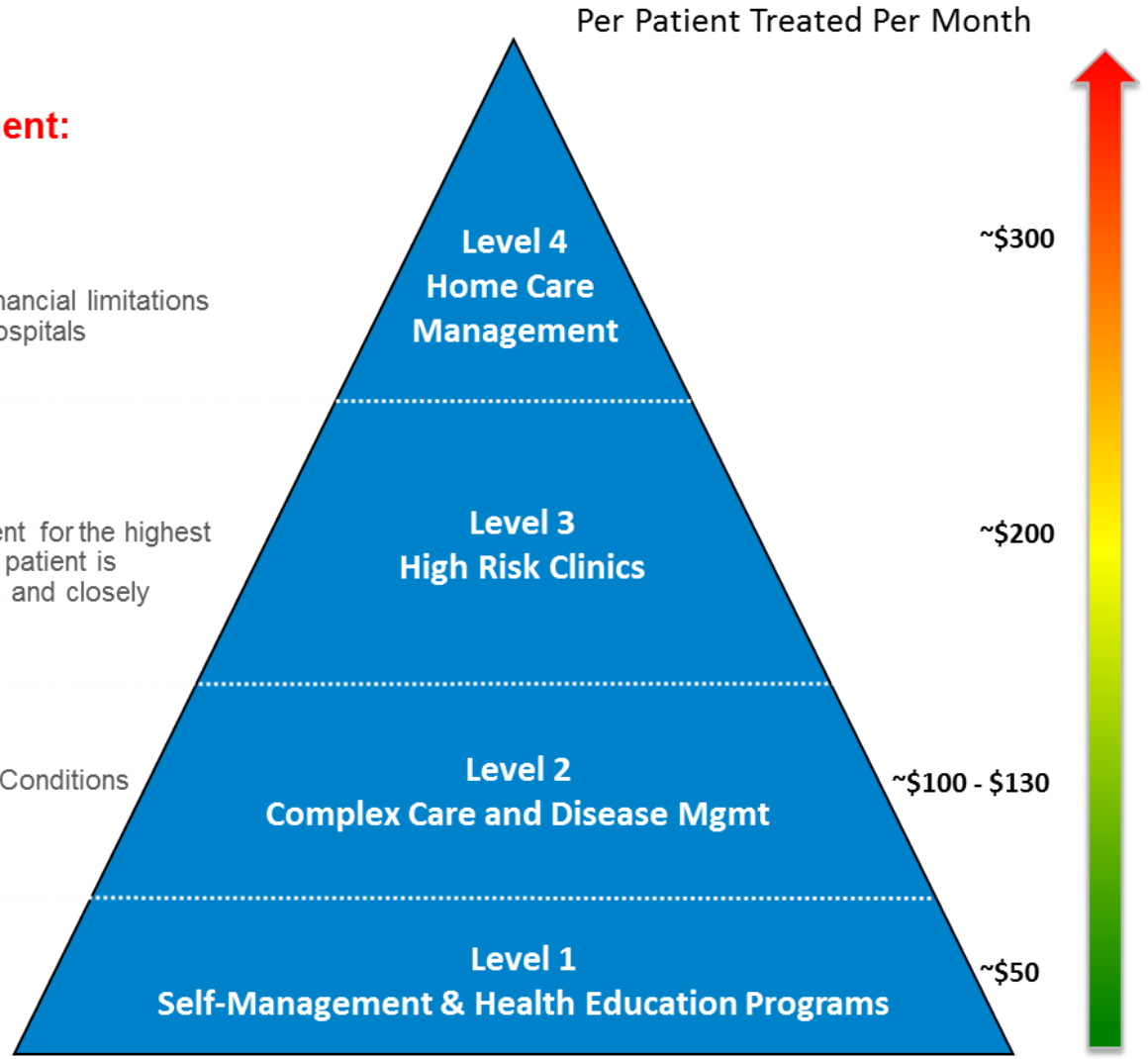
Complex Care and Disease Management

Long-term, whole person care using a multidisciplinary team approach. Conditions include Diabetes, COPD,

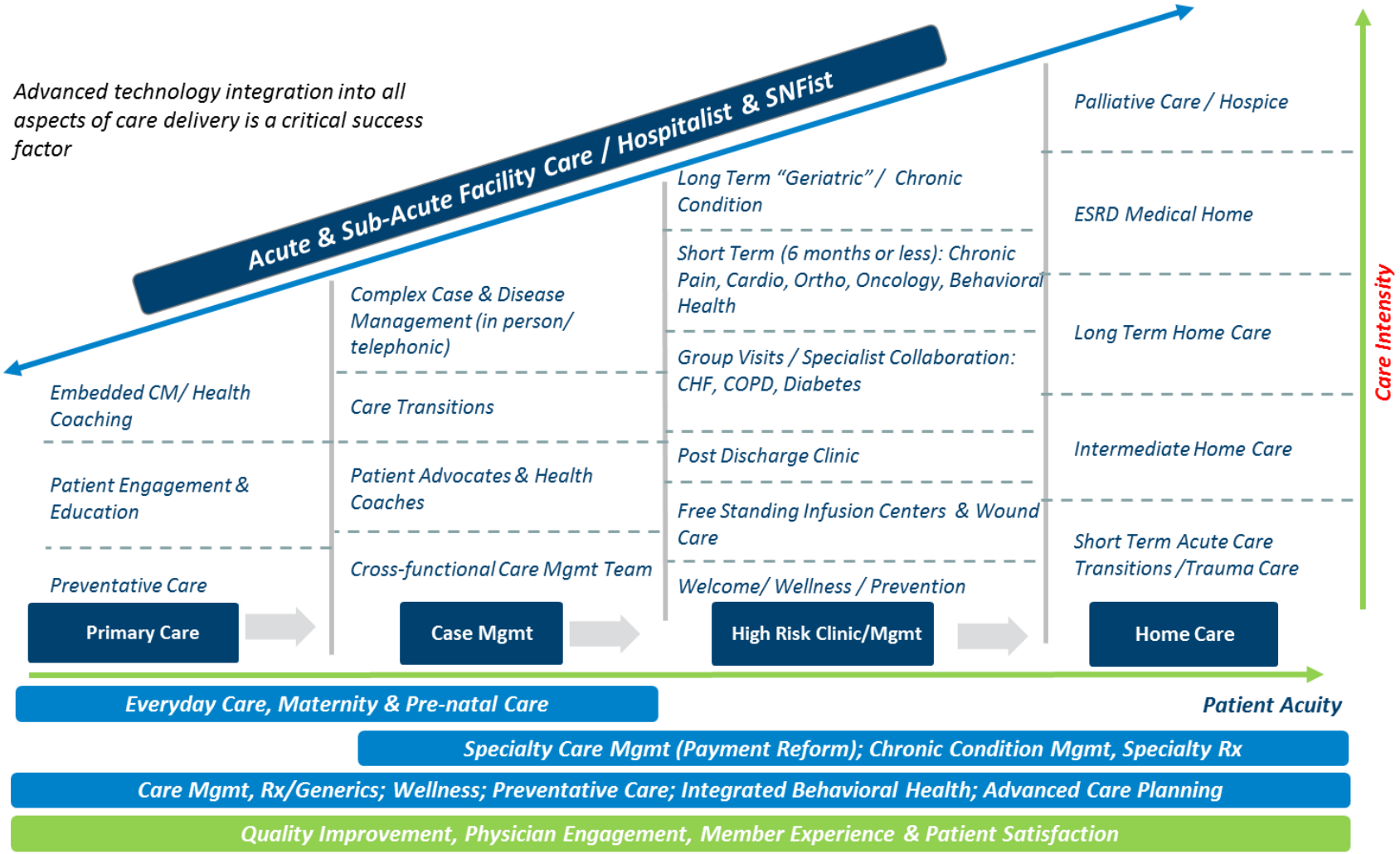
CHF, CKD [ESRD-PCMH], Depression, Dementia

Self Management, PCP

Everyday Care and self-management for people with chronic disease.



Recommended clinical programs



Risk stratification creates value-based delivery systems from existing assets

Employed	Contracted
"Great"	**"Excellent"**
• Embed Care Mgmt. • Shift 1% – 2% Seniors/ 0.5% Comm* • 30/ 1000 senior members on the Composite Scores for Ambulatory sensitive admission (12 categories as defined by AHRQ) • Readmission rates = 7%	• Embed Care Mgmt. • Shift 8% – 10% Seniors/ 2-2.5% Comm * • 35/ 1000 senior members on the Composite Scores for Ambulatory sensitive admission (12 categories as defined by AHRQ) • Readmission rates = 9%
"Good"	**"Average"**
• Embed Care Mgmt. • Shift 5% – 8% Seniors/ 1.5-2% Comm*	• Shift 20% Seniors/ 5% Comm*

Denotes shift of senior population to high risk care centers

For Commercial patients, target 5% of total patients to enroll in high risk programs

Return on investment

- Care Management: ranges from 2.5:1 to 4:1
- Transitions of Care programs that are well-run but carved out: 1.5:1
- Transitions of Care programs that are embedded in integrated care delivery systems: 3:1
- Hospitalist/SNFist programs: 5:1
- Home Care and High Risk clinical programs: 7-15:1
- **Embedding programs in integrated delivery systems yields the highest ROI**

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Questions?

Use the question box on the Zoom screen

To access our materials and the recording of this webinar, please visit: http://hcttf.org/bundled-payments/

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Upcoming Webinars

October

The Dimensions of Value Transformation

- Introduction of the Dimensions of Transformation Strategic Framework, an overview of the recently released Transformation to Value reports, and case studies from real organizations who have gone through the value transformation process

To stay up-to-date on our newest content please visit our website: http://hcttf.org

Learn more

To learn more about the models described today, please contact:

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