Southwestern Health Resources: Approach to MACRA, MIPS, APM, and Risk

The Leadership Institute
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Southwestern Health Resources™
Texas Health Resources®
UT Southwestern Medical Center

Executive Summary: Circa 10/2016

- Southwestern Health Resources Physician Network has an opportunity to significantly increase revenue by accepting two-sided risk in its ACO for the Medicare Shared Savings Program in 2017

- The revenues achieved above create the opportunity to:
  - Keep an adequate network of physicians engaged in the Medicare FFS model
  - Allow the PN to offer a strongly differentiated ACO offering in the market by qualifying as an Alternative Payment Model under the new Medicare FFS payment model known as MACRA
  - Allow the PN and PHSC to be not only self sustaining, but also to create significant distributions to the parents
  - Allow the PN and PHSC to achieve more quickly the ability to accept delegated risk in both the commercial and governmental markets, thereby unlocking significant economic value for the PN and the parents

- SWHR PN believes that we can achieve the above within very reasonable bands of risk consistent with our financial stewardship requirements

Highlighted Advantages of NextGen

- Benchmark reference point is always 2014 population performance for attributed network doctors which buffers the effect of year over year reductions in the national/regional actual spending for Medicare FFS beneficiaries
- The upside is significantly higher with NextGen. SWHR ACN performance has shown declining costs (albeit minor) over prior years and remains well below the regionally adjusted projected benchmarks.
- Benefit enhancement tools available only in Next Gen allow stronger beneficiary engagement, including reward payments
- Coding improvement (critical to all risk/gainshare contracts) is allowed and will increase payments (up to 3%). Track 3 does not allow coding improvements to influence payments.
- More selective approach to physician selection/de-selection

Value of a Larger Upside Opportunity in NextGen

- Strategic intent of the SWHR PN and PHSC is that they will be not only self-supporting, but actually income producing to the parents over time
- Most of our current commercial ACO contracts provide PMPM Care Coordination dollars which are very helpful in mitigating PN and PHSC expenses, but the Shared Savings opportunities available at this time generate little cash flow even with optimal performance
- Government programs carry a much higher PBPY premium than Commercial contracts creating, with the right benchmark, the potential for significant savings generation
- The funds flow potential of NextGen, if achieved, can allow the PN to create "payor agnostic" incentive pools for network physicians that mitigate the limited yield of incentive payments in Commercial contracts and eliminates the difficulties of managing "contract by contract" performance in the PN

Value of a Larger Upside Opportunity in NextGen

- Larger PN incentive pools create a differentiated physician model in the market compared with other models for both the employed and independent physician
- Like MSSP Track 2 and 3, meets the MACRA definition of an APM which will, for the PCPs and some Specialists, mean FFS payments at 105% of Medicare and exemption from MIPS
- Increased likelihood of distributions to parents

Milliman Benchmark Range Summary

Working Draft – Preliminary Summary

		2017		* 2018	
Risk Adjustment	**Scenarios**	**Track 3**	**NG**	**Track 3**	**NG**
0%	Low Band - 0.7% Difference in Benchmark	$12,645	$12,387	$12,898	$12,622
0%	High Band - 3.3% Difference in Benchmark	$12,984	$13,119	$13,244	$13,368
	^SWHR _ACN Actual 12 Month Performance	$11,415	$11,415	$11,643	$11,643
	% Increase in UM To Breakeven (Low Band)	10.8%	8.5%	10.8%	8.4%
	% Increase in UM To Breakeven (High Band)	13.7%	14.9%	13.7%	14.8%
3%	Risk Adjustment (0.7%) Diff in BM	$12,645	$12,770	$12,898	$13,013
3%	Risk Adjustment (3.3%) Diff in BM	$12,984	$13,525	$13,244	$13,781
	^SWHR _ACN Actual 12 Month Performance	$11,415	$11,415	$11,643	$11,643
	% Increase in UM To Breakeven (Low Band)	10.8%	11.9%	10.8%	11.8%
	% Increase in UM To Breakeven (High Band)	13.7%	18.5%	13.7%	18.4%

* Assumes 2% expense growth in '18

^ Most recent rolling 12 month performance from June '15 - May 31, '16

Aggregate Analysis of Miiliman High/Low Models

	Benchmark	Beneficiaries	Expected Spend	Current Actual	Savings	Maximum Opportunity/Risk	Incr. Savings Opp.
Milliman Low	$12,387	80,000	$990,900,000	$913,200,000	$77,700,000	$148,600,000	$70,900,000
Milliman Low RA	$12,770	80,000	$1,022,000,000	$913,200,000	$108,800,000	$153,300,000	$45,500,000
Milliman High	$13,119	80,000	$1,050,000,000	$913,200,000	$136,800,000	$157,500,000	$20,700,000
Milliman High RA	$13,525	80,000	$1,082,000,000	$913,200,000	$168,800,000	$162,300,000	0

Incremental Value Opportunity

	Timeframe 01/01/2015 - 12/31/2015			Timeframe 04/01/2015 - 03/31/2016			Timeframe 07/01/2015 - 06/30/2016		
	UTSACN	All MSSP ACOs	Potential Impact	UTSACN	All MSSP ACOs	Potential Impact	UTSACN	All MSSP ACOs	Potential Impact
Total Person Years	65,242	12,107		80,046	11,640		79,904	11,569	
Total PMPY	$11,401	$9,982	$92,603,970	$11,317	$10,124	$95,543,951	$11,415	$10,100	$105,045,874
Component Expenditures per Assigned Beneficiary									
Hospital Inpatient Facility, Total	$3,814	$3,164	$42,424,123	$3,692	$3,209	$38,620,319	$3,761	$3,246	$41,176,206
Short-Term Stay Hospital	$2,740	$2,740	$0	$2,659	$2,829	$0	$2,718	$2,827	$0
Long-Term Stay Hospital	$334	$79	$16,649,237	$314	$81	$18,689,599	$305	$75	$18,431,115
Rehabilitation Hospital or Unit	$616	$216	$26,068,807	$604	$210	$31,558,300	$612	$204	$32,569,724
Psychiatric Hospital or Unit	$92	$78	$886,441	$72	$77	$0	$81	$77	$283,565
Skilled Nursing Facility or Unit	$854	$700	$10,030,803	$767	$721	$3,680,117	$745	$703	$3,342,463
Institutional (Hospital) Outpatient Facility	$1,859	$1,959	$0	$1,818	$1,997	$0	$1,860	$2,027	$0
Part B Physician/Supplier (Carrier)	$3,626	$3,270	$23,205,658	$3,773	$3,266	$40,627,288	$3,790	$3,268	$41,749,615
Evaluation and Management	$1,246	$1,162	$5,496,193	$1,259	$1,129	$10,379,239	$1,258	$1,129	$10,296,951
Procedures	$936	$856	$5,189,916	$960	$845	$9,228,069	$974	$852	$9,771,707
Imaging	$306	$252	$3,496,174	$323	$253	$5,647,394	$322	$250	$5,704,596
Laboratory and Other Tests	$382	$305	$5,078,599	$412	$297	$9,229,461	$404	$289	$9,199,027
Part B Drugs	$446	$348	$6,376,986	$482	$350	$10,537,004	$482	$360	$9,715,932
Ambulance	$113	$124	$0	$106	$125	$0	$105	$122	$0
Home Health Agency	$1,025	$514	$33,350,157	$1,007	$503	$40,313,296	$989	$498	$39,239,665
Durable Medical Equipment	$294	$256	$2,489,394	$299	$269	$2,378,895	$301	$265	$2,880,872
Hospice	$266	$202	$4,182,978	$265	$212	$4,268,716	$243	$205	$3,057,380

*** Please note this information is pulled from the CMS expenditure files. Component Expenditures have overlapping services, so not completely additive. Illustration of potential in each of the major categories.**

NextGen Risk Assessment/Mitigation

Working Draft – Preliminary Summary

	NextGen	Track 3
Beneficiaries	81,000	81,000
PBPY	12,400	12,400
Total Estimated Spend	$1,004,400,000	$1,004,400,000
Estimated Reserve	$20,088,000	$10,044,000
Maximum Opportunity	$150,660,000	$102,448,800
Maximum Exposure w/o Re	-$150,660,000	-$63,277,200
Maximum Exposure w/ Re	-$48,412,080	TBD
Reinsurance Quote Summary		
Estimated Reinsurance @.0062	$6,227,280	TBD
Low Cost Estimate w/Re - 3%	-$36,359,280	TBD
High Lost Estimate w/Re - 15%	-$48,412,080	TBD
Low Cost Estimate w/o Re - 3%	-$30,132,000	TBD
High Lost Estimate w/o Re - 15%	-$150,660,000	TBD

What do we have in the end with a PN that is Participating in NextGen?

- An ACO that qualifies as an APM for purposes of MACRA
- A Network with the opportunity to generate up to $150 million in retained savings
- A Network that has a rolling 12 month actual PBPY expense that is ~$1000 PBPY below Milliman's lowest estimate for NextGen benchmark target expenses
- Based on current actual expense and lowest estimated benchmark, realized savings for 2017 would be ~$80 million
- Over $100 million in expense reduction opportunity compared to average national ACO performance, with the vast majority of that expense reduction opportunity representing "other people's money"
- A self-supporting Network that can offer significant incentive opportunities to high performing physicians in a "payor agnostic" way that should be differentiated in the market

What do we have in the end with a PN that is Participating in NextGen?

- A Network and PHSC that can develop the capabilities to accept and manage delegated risk in both the governmental and commercial markets while mitigating or eliminating the burden of development born by the parents

- A Network with a compelling value proposition to both Specialists and Primary Care physicians, to both Employed/Faculty and Independent physicians that includes

  - Significant support for the cost of infrastructure required for Clinical Integration
  - Market differentiated FFS contracting
  - Exemption from MIPS via an APM or significant support to optimize performance in MIPS for network physicians who do not qualify as eligible providers in the APM
  - Significant Population Health Management infrastructure that can help physicians unlock value in both the governmental and commercial markets
  - Performance based incentive pools at a scale that is differentiated in the market

Issues That Arose That Might Force SWHR To Rethink

- Did not get our data as promised in mid-December, 2016; received data files 1/24/2017 on our projected full cohort of ~84,000 beneficiaries from 2013-2016
- Data to Milliman and Hanover
- Received benchmark and risk score for about 57,000 beneficiaries who were part of the initial 2011-2013 alignment period on 2/01/2017;
- Calculated high and low risk bands for that cohort based on the +/- 3% range for the NextGen final risk score corridors
- Reserve requirement received; calculated on the smaller cohort, so the requirement actually was less than anticipated
- Final MC exclusions determined and cohort is 76,649
- Awaiting final Milliman analysis and confirmation from Hanover on reinsurance as of 2/13/2017

Potential Outcomes for the Unaccounted Cohort

- The currently unaccounted cohort (~20,000 beneficiaries) is a Low Risk and Low Cost cohort: the math probably works at current state because of the -3% floor for downward risk adjustment at final reconciliation (the unaccounted cohort cannot hurt the base cohort enough to drive down the overall risk score too much and the costs are still low)

- The currently unaccounted cohort is High Risk and Low Cost: the math works at current state performance (risk score goes up and the historic costs go down); unlikely scenario

- The currently unaccounted cohort is Low Risk and High Cost: the math doesn't work at all at current state performance

- The currently unaccounted cohort is High Risk and High Cost: the math at current performance depends on how much higher the costs are to the market, as the upward risk adjustment is capped at +3%

Potential Decisions for SWHR ACO

- Drop out of NextGen by 2/28/2017
  - Current state performance risk is too high for management/governance tolerance, independent of cost reduction opportunities
  - Current state performance risk precludes acceptable reinsurance availability and/or cost
  - Decide that the value of being the only MACRA APM in market is insufficient given the current state performance risk
  - Focus on Commercial opportunities in 2017 (limited $$$ value at this time) and reassess MC ACO options for 2018

- Stay in NextGen for 2017
  - Already managing as if we are (post-acute model, network efficiency)
  - Current state performance risk comes in at an acceptable level, and cost reduction opportunities seem achievable
  - Reinsurance comes in as expected
  - We have the only in market MACRA APM that can offer MIPS exemption for 2019 and 105% MC fee schedule adjustment for 2019