# Working with Community Physicians: Two Alternative Models

- **"UT Southwestern Clinically Affiliated Physicians: (UTSCAP) are ~350 community-based self-employed PCPs who are Clinically Integrated**

- **"Southwestern Health Resources ACO": A unique public/private partnership that combines 31 Hospitals/Facilities and 2700 physicians in one clinically integrated network**

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# The Problem

- **Like most AMCs:**
  - Deeply tertiary and quaternary faculty
    - 1750 faculty = ~1100 Clinical FTEs
    - 84 faculty PCPs = ~45 Clinical FTEs
  - ~2000 patients per PCP FTE = 90,000 population
    - Insufficient to maintain tertiary and quaternary programs
      - e.g. NCI Cancer Center or Transplant programs
    - Insufficient population to maintain subspecialty Fellowships
    - Insufficient to population support clinical and translational research
  - Facing exclusion from side-by-side and narrow networks
  - MACRA/MIPS payment threat
  - Payment Reform towards fee-for-value
  - Perception of being the 'highest cost' providers
    - Lack of useful comparator data
    - Unit costs v. total costs of care

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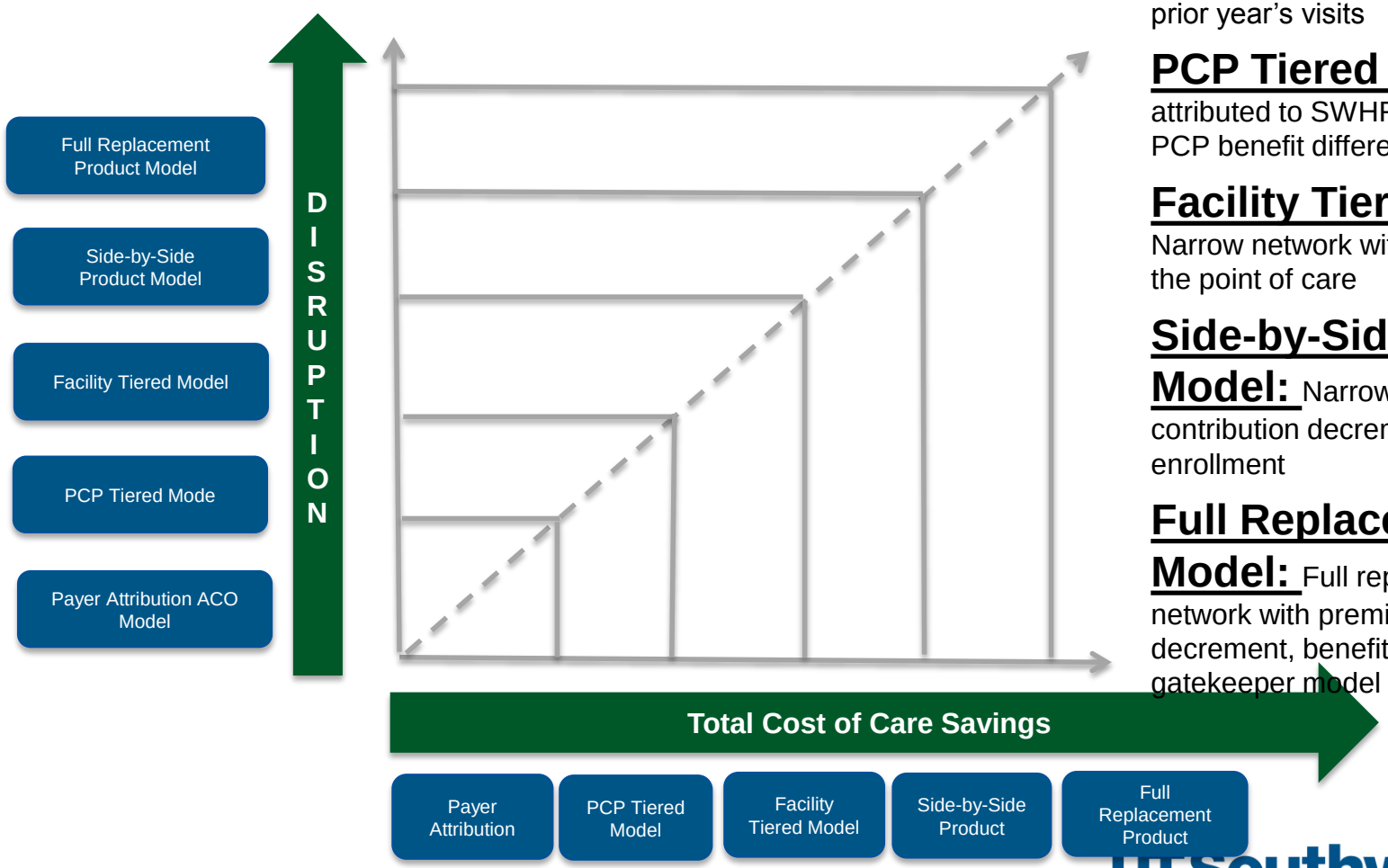
# Employers Transitioning




**Payer Attribution ACO:** Member attributed to SWHR PCP from prior year's visits

**PCP Tiered Model:** Member attributed to SWHR PCP as a result of PCP benefit differential (copay reduction)

**Facility Tiered Model:** Narrow network with benefit differential at the point of care

**Side-by-Side Product Model:** Narrow network with premium contribution decrement at the point of enrollment

**Full Replacement Product Model:** Full replacement narrow network with premium contribution decrement, benefit differential and gatekeeper model

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# MACRA Physician Fee and Incentive Timeline


*Qualifying APM conversion factor
**Non-qualifying APM conversion factor

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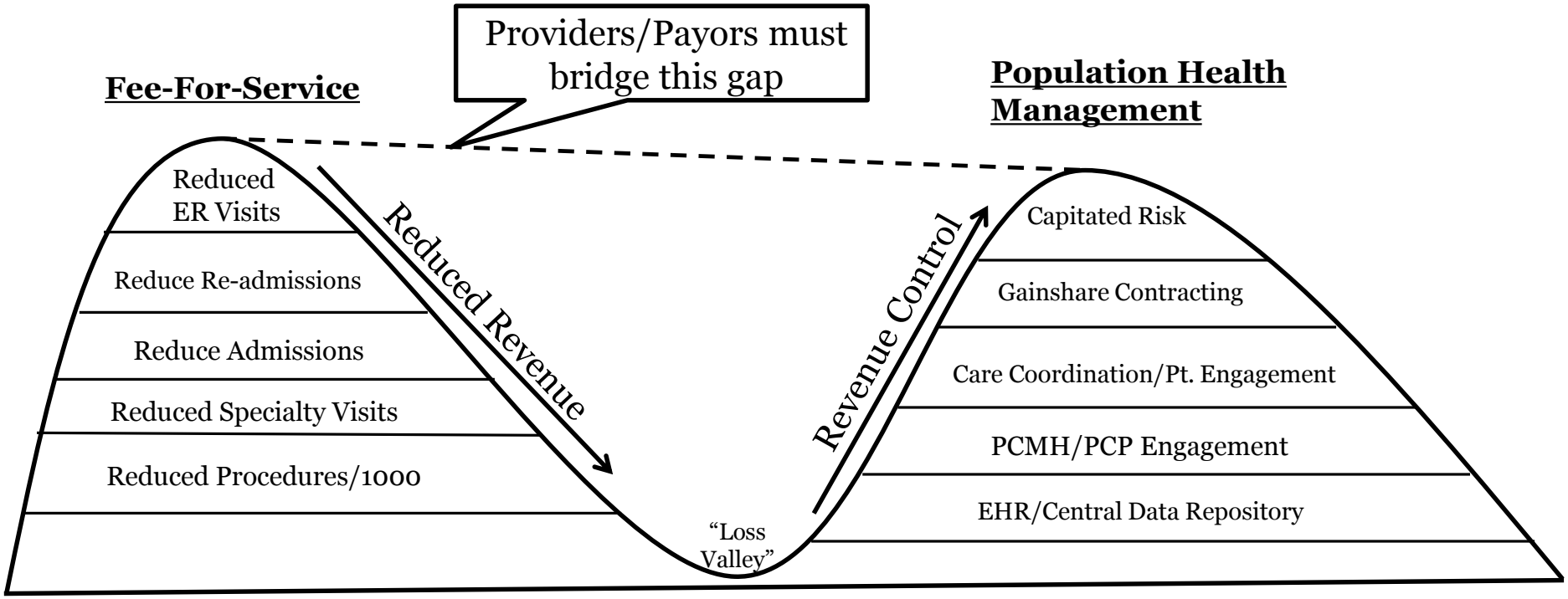
# Payment Reform and Population Health Transition




•Expanding capability to manage care effectively and efficiently while growing the number of contracted covered drives quality and value

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# Solutions: Part I

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***UT Southwestern***
***Clinically Affiliated Physicians***

**(UTSCAP)**

**Clinically Integrated**
**self-employed**
**community-based**
**PCPs**

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# UTSCAP Requirements

- **No Faculty appointment**
- **Baseline Clinical Integration Requirements**
  - Install Qualified EHR (within 6 months)
  - Connect EHR to CDR
  - Implement Referral Management App
  - Initiate Press Ganey Patient Experience Evaluations
  - Geographic POD Meeting Attendance
  - Use Financial Performance and Quality Dashboards
    - Monthly pushed reports on quality performance and total costs of care
    - Transparent with all other PCPs

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# UTSCAP Requirements continued

- **Quality Activities**
  - Regular Review of Primary Care and Specialty Provider Quality Reports
  - Use of Point-of-Care Tool
    - Risk Stratification and Notifications
    - Care Gap and Coordination
  - Use Preventative Care Outreach Tools
  - Use Chronic Care Best Practice Outreach Tools
  - Clinical Care Protocol Development Participation and Adherence
  - PCMH qualification assistance

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# UTSCAP Requirements continued

- **UM / UR Activities**
  - In-Network Efficiency
    - Access / Scheduling / Referral Network use
  - Post-Acute Care Network Protocols and Efficiency
  - ED Tool Kit Implementation
  - Access / Extended Office Hours (within PODs)
  - Mandated Education / Audits
    - Population Health principles and total cost-of-care

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# UTSCAP Governance and Committee Structure

- **Board Structure with Equal Representation**
  - 5 members each (UTSW and Community Physicians)
- **Utilization Management**
  - Hospital Transitions
  - High Cost Imaging
  - Referral Management
  - Telemedicine
- **Clinical Integration**
  - Data Standards
  - EHR Governance
  - Care Gap Closure and Coordination
  - Clinical Care Pathways
  - POD Governance and Coordination
- **Quality Assurance**
  - GPRO and other required Reporting
  - Quality Standards
  - Quality Reporting (Scorecards)

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# UTSCAP Functionality

- **CDR / HIE Inputs**
  - Payer Claims Data
    - Managed Care Payers
    - CMS
    - State Medicaid
  - EHR
    - EPIC (including Community Connect)
    - eCW
    - NextGen
  - Member Match
  - Risk Stratification/ Care Gap Identification software
  - Outcomes/Quality reporting
  - Total Costs-of-Care reporting

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# UTSCAP Value Proposition

- **IT infrastructure support and underwriting**
- **Population Health tools and infrastructure**
  - Quality and Total cost-of-care reporting
  - Detailed by provider and facility
- **Alternative Payment Model avoids MIPS**
  - Support for all required reporting
  - MSSP Track I converted to Next Gen model
    - *With financial backstop*
- **Governance Equity**
- **PCMH qualification assistance**
- ***Quality Improvement Incentive Fund***
- ***Joint Network Contracting***
- ***Shared Savings Opportunities***

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# UTSCAP Keys to Success

- **What resources are necessary?**
  - Network of high quality and efficient specialists
  - Referral management support
  - Patient navigation assistance
- **How success will be measured?**
  - Purpose-built network efficiency percentage
  - Patient satisfaction
- **Call to action**
  - Refer within purpose-built network with referral management tools
  - Experience of Care accountability
- **Management of post-acute spend**
  - Preferred network of Home Health, SNF, LTAC, IRF)
- **Reduce ER utilization**

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# Solutions: Part II

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Texas Health Resources

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# Southwestern Health Resources

- **A unique public/private partnership that combines 31 Hospitals and 2700 physicians in one clinically integrated network with an underlying Population Health Services Company serving all entities**

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# Southwestern Health Resources

- **UT Southwestern Health System**
  - University Hospitals (610 beds)
  - 11 Ambulatory Centers
  - **Clinically Integrated Physician Network**
    - Faculty Practice Plan: ~1,750 physicians
    - UTSCAP – UTSW clinically affiliated physicians ~350 physicians
- **Texas Health Resources**
  - 27 acute care and rehabilitation hospitals and surgicenters
  - Texas Health Physicians Group (employed)
    - ~600 physicians (240 PCPs)
    - More than 5,500 physicians with active staff privileges
      - (90% independent)
- **ACO Structure**
  - Extended Physician Network allows for independent specialty physicians to contract together for gain-share and risk-based contracts while maintaining independent practice
  - Population Health Infrastructure access
  - Quality Improvement Fund access

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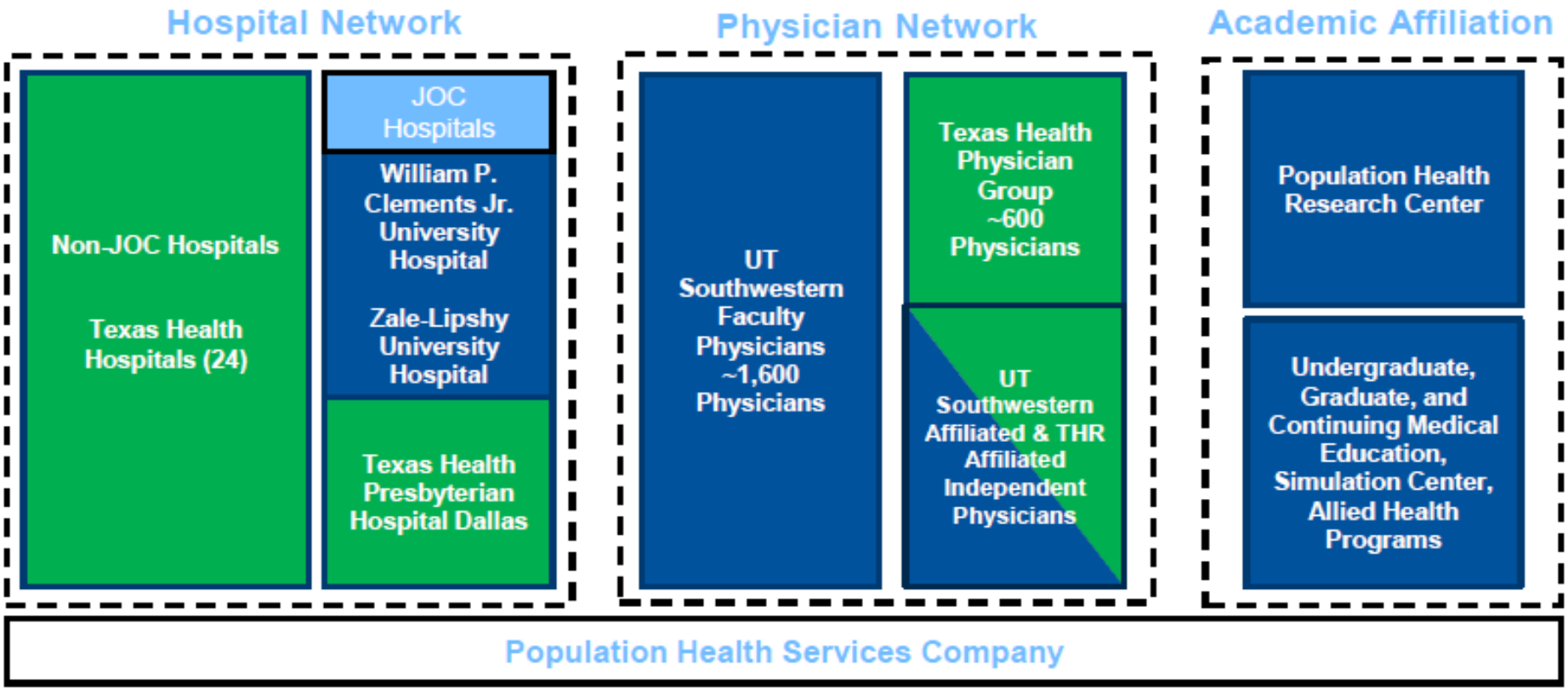
# Southwestern Health Resources

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# Texas Health Physician Group (THPG)

- **Employed Physicians ~600 physicians**
  - ~250 PCPs
- **Not purpose built for population management**
  - Employment driven by hospital volumes (specialists) and inpatient needs (hospitalists)
  - Geographic maldistribution of specialists
  - Converting to EPIC Community Connect EHR
- **Three year (successful) experience with Medicare Advantage**
- **Two years in MSSP Track I**
- **Single signature authority**
- **40% of income through incentives**
- **PCPs have heavy use of APPs**

- **Same integration requirements as UTSCAP**
- **Same population Health infrastructure**

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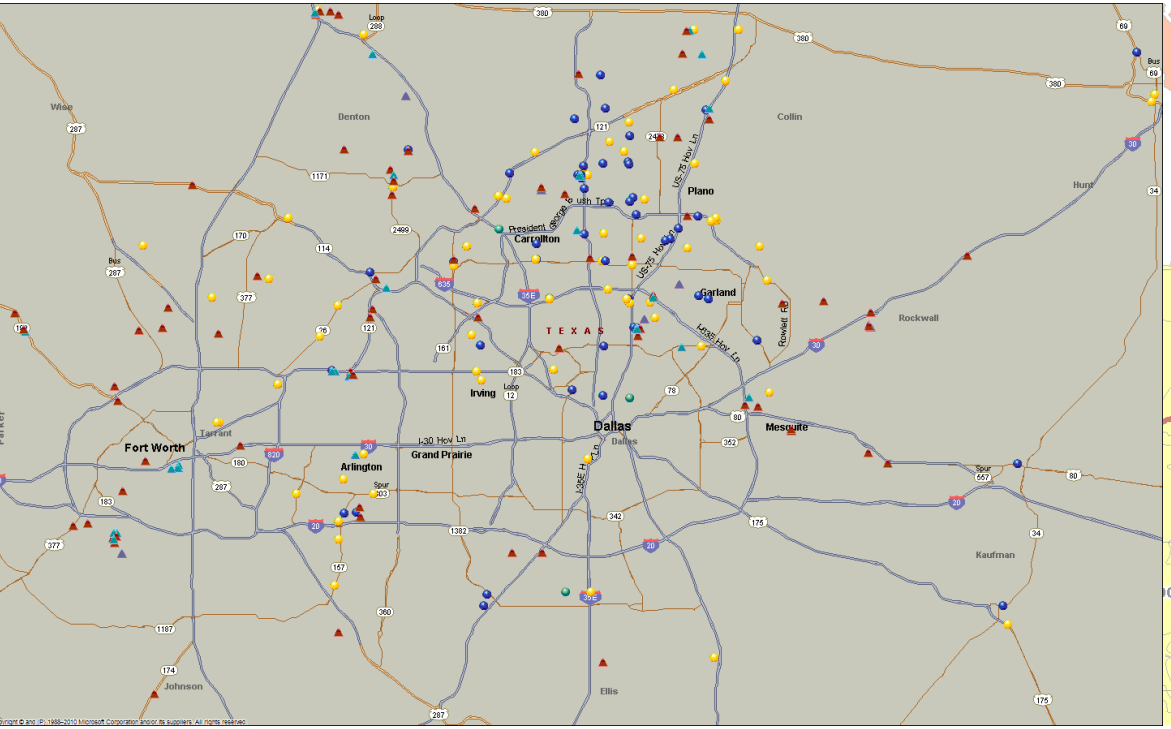
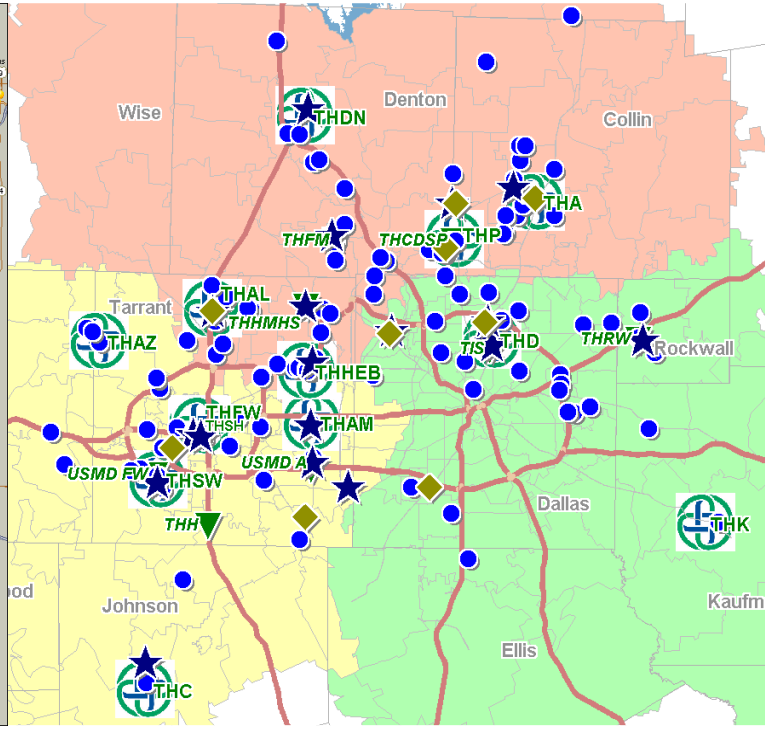
# SHWR ACN Network Map

## Primary Care Physicians




## Facilities




**SWHR PCPs**

| | |
|---|---|
| UTSCAP | = 343 |
| UTSW Faculty | = 84 |
| THPG | = 243 |
| SWHR PCPs | = 670 |

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# What are we doing?

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# Population Health Services Company

- **Scope of Services:**
  - **Data Analytics/Actuarial Analysis and Workflow Platform**
    - Risk stratification
    - Predictive modeling
  - **Practice-Centric Services**
    - Scheduling/Access/Referral Management/Care Navigation
    - EMR and IT Services for Physician Groups
  - **Care Coordination Services**
    - Care Gap Identification/Closure
    - Care Transitions Management
    - Chronic Disease Management/Care Models
  - **Care Administration Services**
    - Utilization Management/Review (esp. Post-Acute Care)
    - Bundles Administration
  - **Quality Improvement**
    - Dashboard and specific goals
  - **Total Cost-of-Care Performance Dashboard**
  - **Patient Experience and Engagement**
  - **Post-Acute Care Network** with Scorecard

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# Alternative Payment Models

- **Medicare Shared Savings Program**
  - 84,000 covered lives
  - Saved $30M in 2015 (8th of 392 programs)
  - Enrolled in NextGen – 15% up and down risk on $1.1B cost
- **Medicare Advantage**
  - 18,000 covered lives
- **Commercial Risk-based contracts and Bundles**
  - 240,000 covered lives
- **Programs for decreasing medical costs for employees and their dependents**

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# Results

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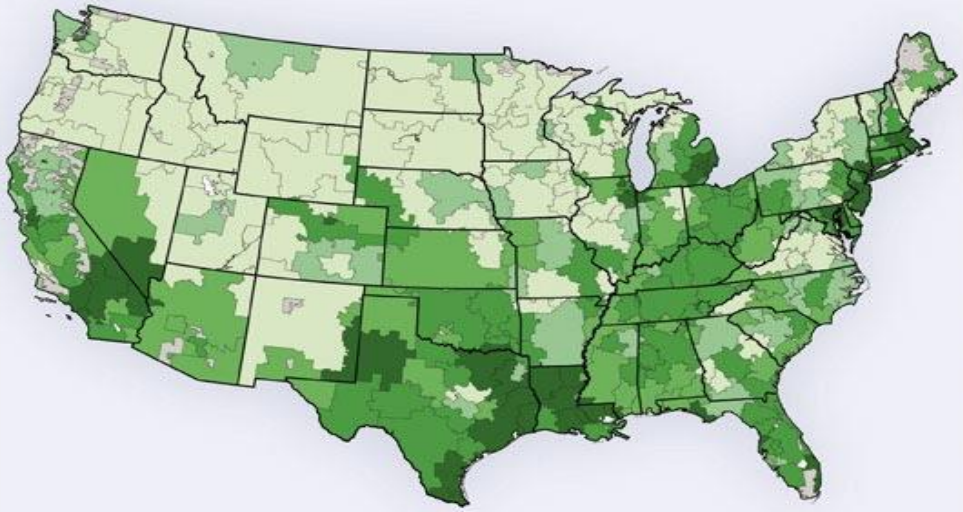
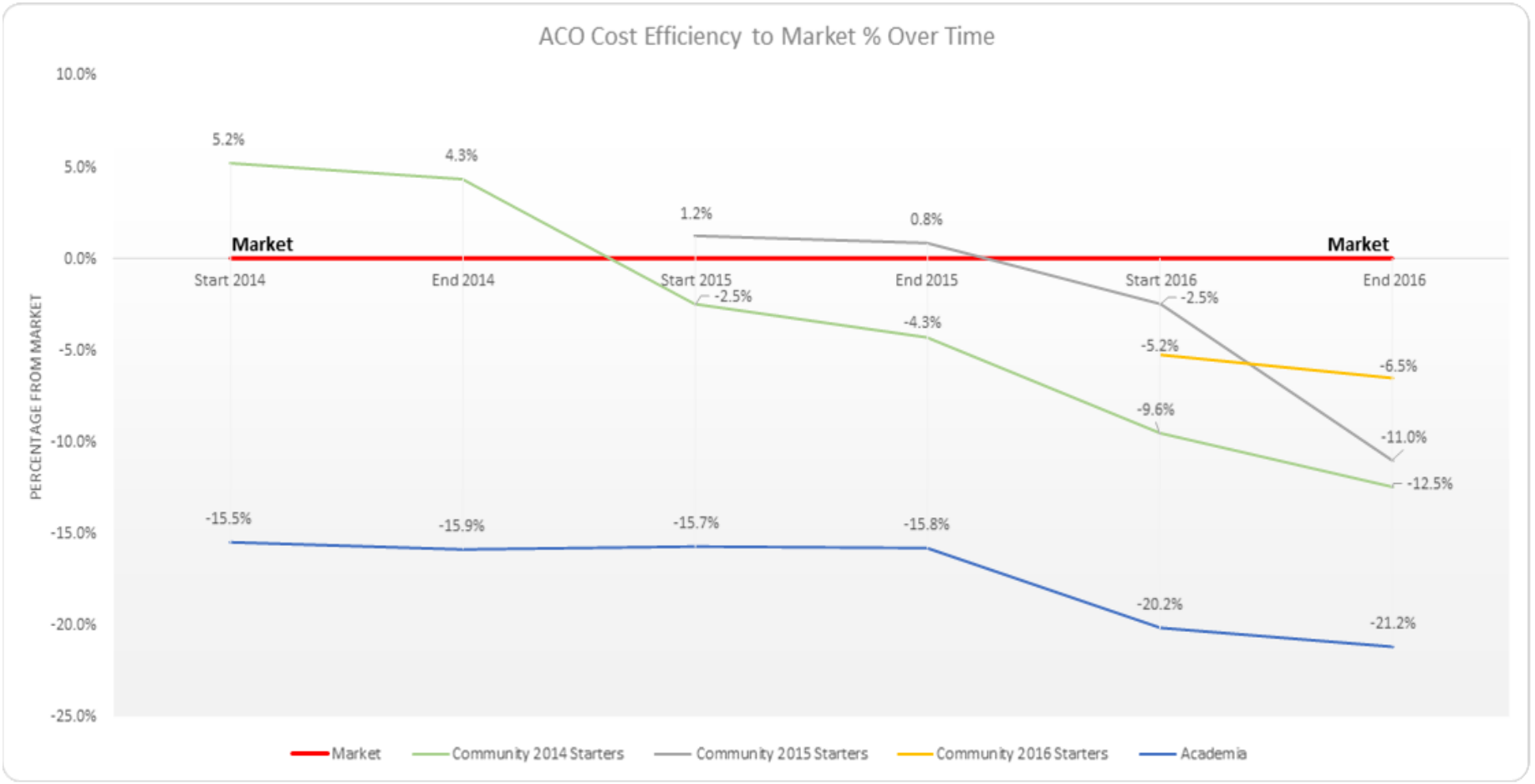
# Slowing the Growth of Health Care Costs: Lessons from Regional Variation




| Hospital Referral Region | Medicare Spending, 2006 | Spending Growth, 1992–2006 | Annual Growth Rate, 1992–2006 |
|---|---|---|---|
| Manhattan, NY | $12,114 | $4,979 | 3.9% |
| Los Angeles, CA | $10,810 | $3,707 | 3.0% |
| E. Long Island, NY | $10,801 | $4,525 | 4.0% |
| Dallas, TX | $10,103 | $5,168 | 5.3% |
| Houston, TX | $9,881 | $4,054 | 3.8% |
| Fort Lauderdale, FL | $9,816 | $3,495 | 3.2% |
| Philadelphia, PA | $9,665 | $3,248 | 3.0% |
| Chicago, IL | $9,662 | $3,641 | 3.4% |
| Baltimore, MD | $9,658 | $3,007 | 2.7% |
| Boston, MA | $9,526 | $3,204 | 3.0% |
| Camden, NJ | $9,445 | $3,677 | 3.6% |
| Orlando, FL | $8,588 | $3,179 | 3.4% |
| Pittsburgh, PA | $8,506 | $2,321 | 2.3% |
| Cleveland, OH | $8,377 | $2,660 | 2.8% |
| Nashville, TN | $8,355 | $3,048 | 3.3% |
| St. Louis, MO | $8,306 | $3,374 | 3.8% |
| Columbus, OH | $8,279 | $3,761 | 4.4% |
| Washington, DC | $8,173 | $2,397 | 2.5% |
| Birmingham, AL | $8,062 | $2,887 | 3.2% |
| Phoenix, AZ | $7,890 | $2,748 | 3.1% |
| Charlotte, NC | $7,742 | $3,651 | 4.7% |
| Kansas City, MO | $7,604 | $2,480 | 2.9% |
| Milwaukee, WI | $7,578 | $2,942 | 3.6% |
| Indianapolis, IN | $7,509 | $2,635 | 3.1% |
| Atlanta, GA | $7,363 | $2,004 | 2.3% |
| Albany, NY | $7,255 | $2,794 | 3.5% |
| Seattle, WA | $7,218 | $2,379 | 2.9% |
| Minneapolis, MN | $6,705 | $2,967 | 4.3% |

# Total Cost-of-Care Efficiency to Market

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# Total Cost-of-Care Comparison Over Time

| | Community 2014 Starters | Community 2015 Starters | Community 2016 Starters | Academic |
|---|---|---|---|---|
| **Cost PMPM** | **$751** | **$1,005** | **$910** | **$1,228** |
| **Risk-adjusted Market Cost** | **$858** | **$1,130** | **$973** | **$1,558** |
| **% Market** | **-12.5%** | **-11.0%** | **-6.5%** | ***-21.2%*** |

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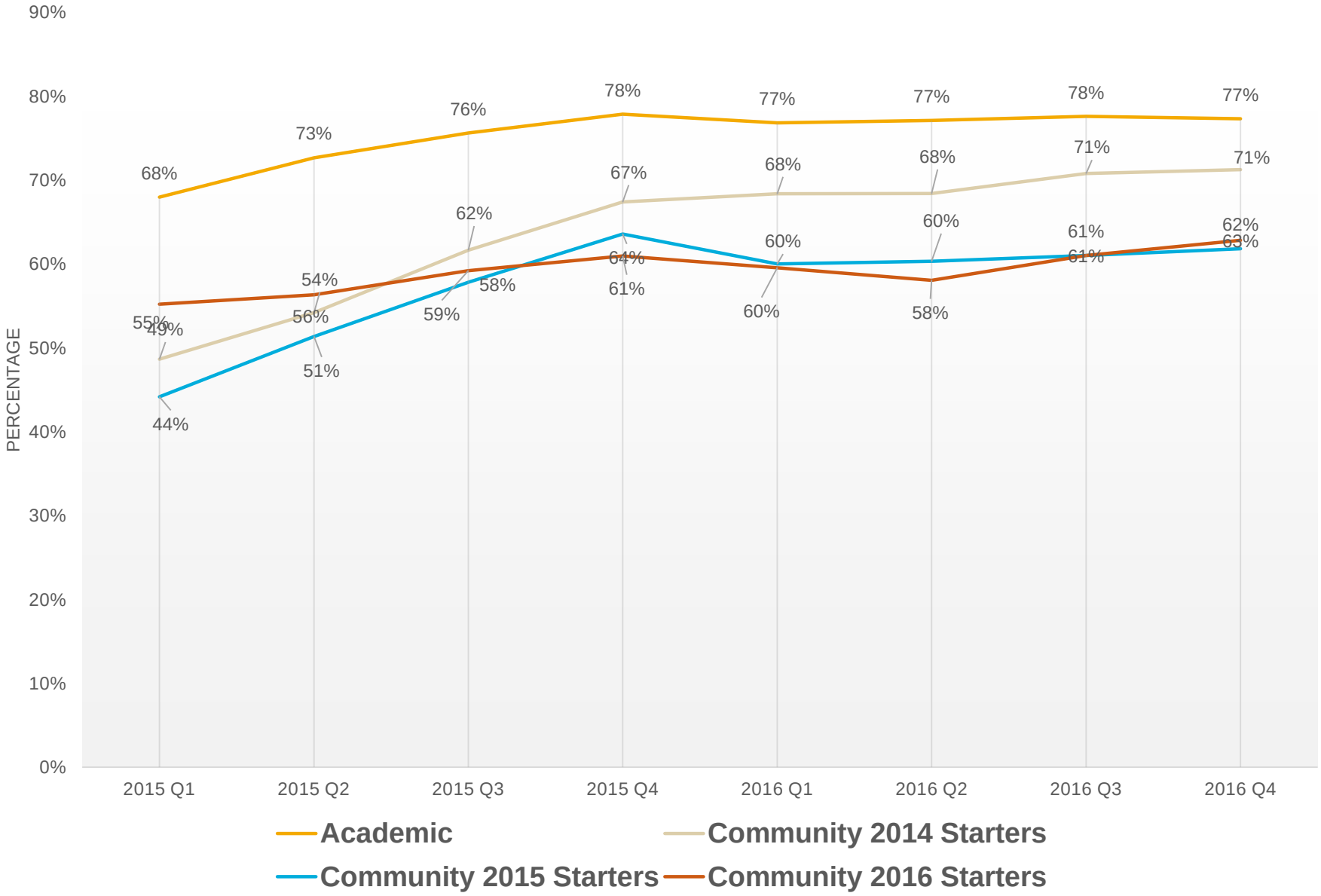
# ACO Quality Measures Trend Across All Populations



| 2015 MSSP | Community 2014 Starters | Community 2015 Starters | Community 2016 Starters | Academic |
|---|---|---|---|---|
| Rehab Days per 1000 | 235.7 | 314.1 | 449.4 | 291.9 |
| Rehab Admissions per 1000 | 19.2 | 27.5 | 38.3 | 24.6 |
| ER PMPM | $31.50 | $41.02 | $40.72 | $42.32 |
| Imaging PMPM | $33.38 | $37.37 | $41.30 | $44.50 |
| Readmission Rate | 14.2% | 13.3% | 11.1% | 19.3% |
| SNF | $43 | $70 | $56 | $34 |
| HHA | $70 | $71 | $79 | $53 |

| 2016 MSSP | Community 2014 Starters | Community 2015 Starters | Community 2016 Starters | Academic |
|---|---|---|---|---|
| Rehab Days per 1000 | 102.1 | 251.5 | 232.4 | 198.9 |
| Rehab Admissions per 1000 | 9.6 | 21.3 | 21.1 | 17.9 |
| ER PMPM | $26.35 | $36.68 | $31.78 | $39.14 |
| Imaging PMPM | $32.95 | $35.91 | $36.99 | $46.79 |
| Readmission Rate | 9.8% | 11.7% | 11.3% | 19.0% |
| SNF | $22 | $42 | $46 | $30 |
| HHA | $64 | $67 | $80 | $51 |

| % Change | Community 2014 Starters | Community 2015 Starters | Community 2016 Starters | Academic |
|---|---|---|---|---|
| Rehab Days per 1000 | -57% | -20% | -48% | -32% |
| Rehab Admissions per 1000 | -50% | -22% | -45% | -27% |
| ER PMPM | -16% | -11% | -22% | -8% |
| Imaging PMPM | -1% | -4% | -10% | 5% |
| Readmission Rate | -31% | -12% | 1% | -2% |
| SNF | -49% | -40% | -18% | -12% |
| HHA | -8% | -5% | 1% | -4% |

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# Physician Network Relations: Lessons Learned

- **Show *Respect* for other employed and self-employed**
- **Physician-driven and directed is important**
  - Cannot allow perception or reality that Hospitals or Academics drive the economic equation
- **Governance Equity is critical**
- **Financial transparency (at least at the Board level)**
- **Structure must put all groups together regularly (with adult supervision when necessary)**
- **Value proposition must resonate**
- **Quality standards must be equal**
  - no one's patients are different
- **EHR interconnectivity is critical**
  - Patient experience
  - Reduce duplication of imaging and testing
  - CDR for equitable comparison and rating
- **Communicate, communicate, communicate**
  - Cannot possibly underestimate suspicion
- **Still comes down to money…**

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# Questions?


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