University Physicians

University of Missouri Health

APPD Fall Meeting
2018

Describe the state of value-based care and population health in your market?

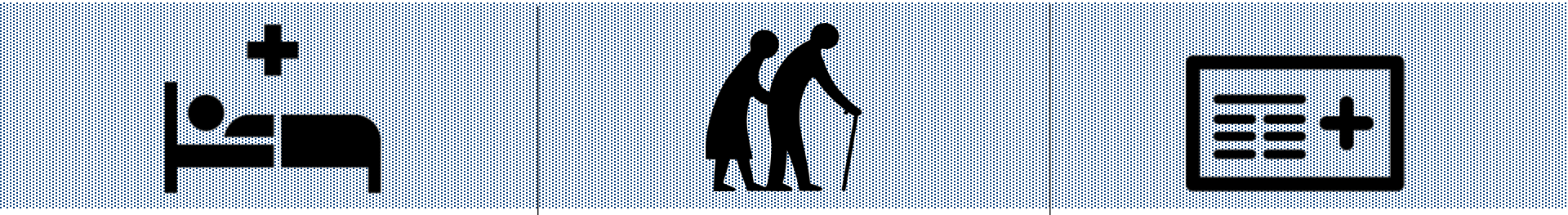
Currently we have 2 value based contracts – Anthem & United – 10%~ of our patient population

We are investing in services and software from both Mercy Health System and Cerner Corporation for care management, analytics, etc. needed to participate in value based care contracts

We are also involved in a “gap analysis” review to determine exactly where we need to start and how to bring the faculty along to be active participants in managing care under VBC contracts

We are in due diligence with a large health system to grow our clinical footprint and create locations to provide lower cost of care IP, OP and ambulatory services

Macro healthcare trends impacting the Missouri Market



Shift from Inpatient to Outpatient Setting

Care delivery is increasingly shifting from an inpatient to outpatient setting. Individuals cases seen in an inpatient environment are becoming increasingly complex.

MU Health Considerations:

For select service lines from 2018 to 2023, the PSA **inpatient demand is expected to decrease slightly,** while **outpatient services will grow nearly 5.5%**

Demographic Shift: Growth in the Aging Population

The U.S. population is aging, especially in rural markets. Care delivery needs are increasingly extending beyond the traditionally defined health care system walls (e.g., home care, hospice).

MU Health Considerations:

From 2018 to 2023, the PSA's **population aged 65+ will increase 15%**, while younger populations decrease or remain mostly stagnant

Increase in Medicare Enrollment

As the population ages, the number of Medicare enrollees increases. Health systems are becoming more dependent on Medicare regulation and reimbursement rates, which place additional pressure on cost-containment strategies.

MU Health Considerations:

From 2018 to 2023 in the PSA, **Medicare covered lives will increase by 13%**, while **Commercial covered lives will decrease**

PSA: Primary Service Area for MU Health, defined by 10-county area of highest Medicare discharges

Source: Truven

Missouri's Medicare population have higher discharge rates compared to national average

Discharges per 1,000 Medicare Enrollees

	2013		2014		2015	
	Rate	Difference	Rate	Difference	Rate	Difference
National average	189.3		181.4		181.9	
Missouri	203.2	+8,712	199.3	+11,215	204.1	+10,447

Ambulatory sensitive discharges per 1,000 Medicare Enrollees

	2013		2014		2015	
	Rate	Difference	Rate	Difference	Rate	Difference
National average	53.8		49.9		49.5	
Missouri	59.1	+3,311	56.6	+4,216	56.6	+3,345

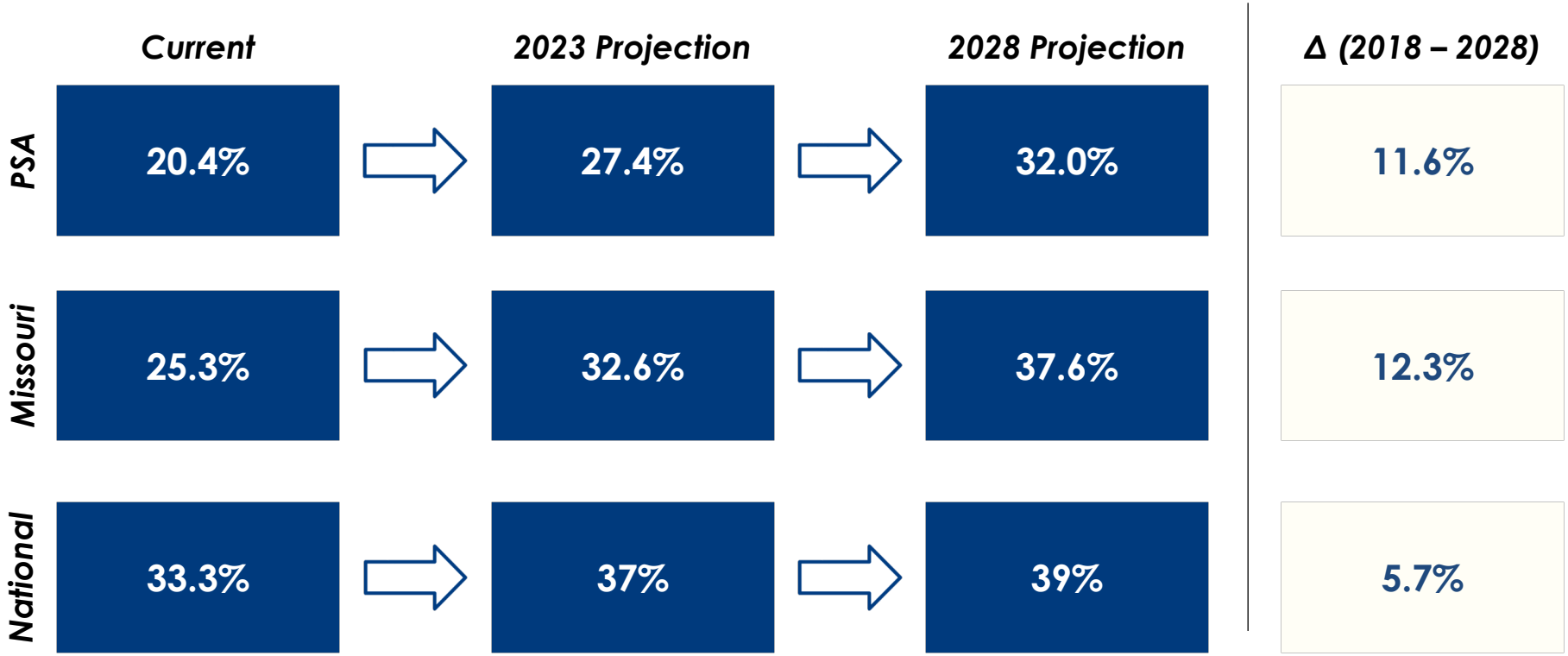
- Missouri has higher **overall and ambulatory sensitive discharges for its Medicare population**, suggesting opportunity to reduce variation in this population through population risk based arrangements (e.g. MA plan)

- Rate: Number of medical discharges or ambulatory sensitive discharges per 1,000 Medicare enrollees in the specific population
- Difference: The number of admissions in excess (+) or reduced (-) in the defined population when compared to the national average

Source: Dartmouth Atlas Medicare Data

Medicare Advantage penetration rate in Missouri is projected to grow faster than national average over 5 – 10 years

Medicare Advantage Penetration Rate Comparisons & Projected Change



- Medicare Advantage penetration rates in **MU Health's PSA and Missouri are currently below national rates but are projected to grow faster than the national rates**, indicating that more reimbursement will be increasingly driven by government payments

Source: Kaiser Family Foundation, MA Enrollment by County

In Missouri, majority of Medicaid enrollees are primarily under Managed Medicaid plans

Medicaid Managed Care Enrollment & Penetration Rates (2013-2016)

	2013	2014	2015	2016
MCO	416K	389K	463K	494K
PHP	429K	409K	459K	467K
Total Medicaid Managed Care Enrollment	844K	798K	922K	961K
Total Medicaid Enrollment	**868K**	**826K**	**944K**	**982K**
Total Managed Care Penetration Rate	**97.2%**	**96.6%**	**97.7%**	**97.9%**

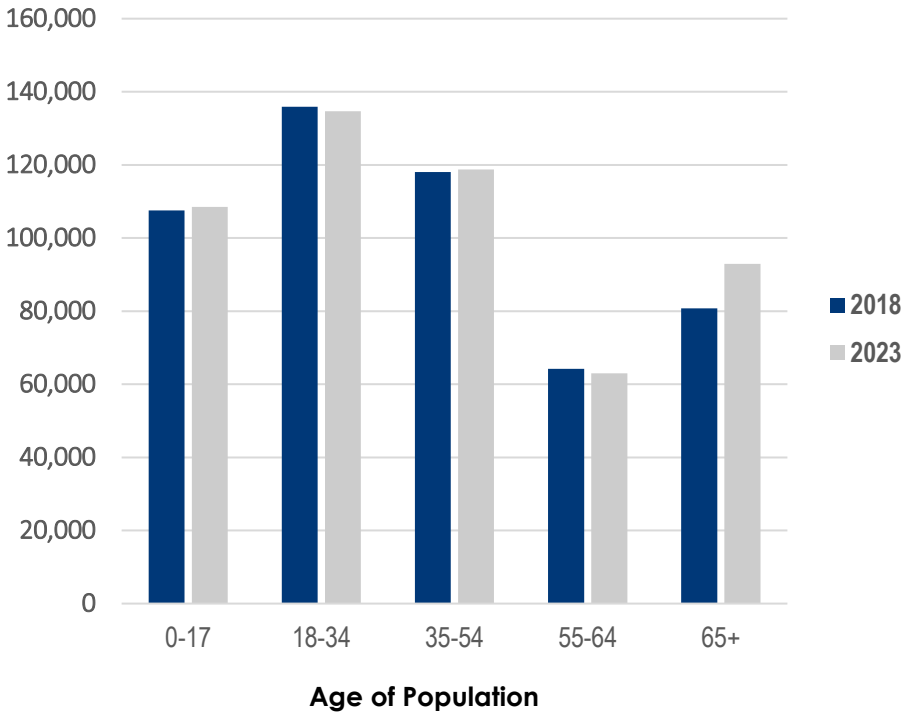
- From 2013 to 2016, total enrollment in managed Medicaid plans in Missouri increased by **117K (13.8% increase)** with high penetration rates (~97% per year since 2013)
- High penetration and growth rates for managed Medicaid population will require **focused value based strategies to effectively manage enrollees to achieve better outcomes at financially sustainable levels**

Definitions:
- **MCO**: *Comprehensive Managed Care Organizations*, which cover acute, primary, and specialty medical care services. They may also cover behavioral health, long-term services & supports, and other benefits.
- **PHP**: *Prepaid Health Plans* (ambulatory or inpatient), which cover a limited set of benefits such as behavioral health, long term care, dental, or transportation benefits.

Source: https://www.kff.org/medicaid/state-indicator/enrollment-by-medicaid-mc-plan-type/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

The population in the PSA is expected to grow ~2% by 2023, with the 65+ cohort growing rapidly

Demographic Projections – PSA

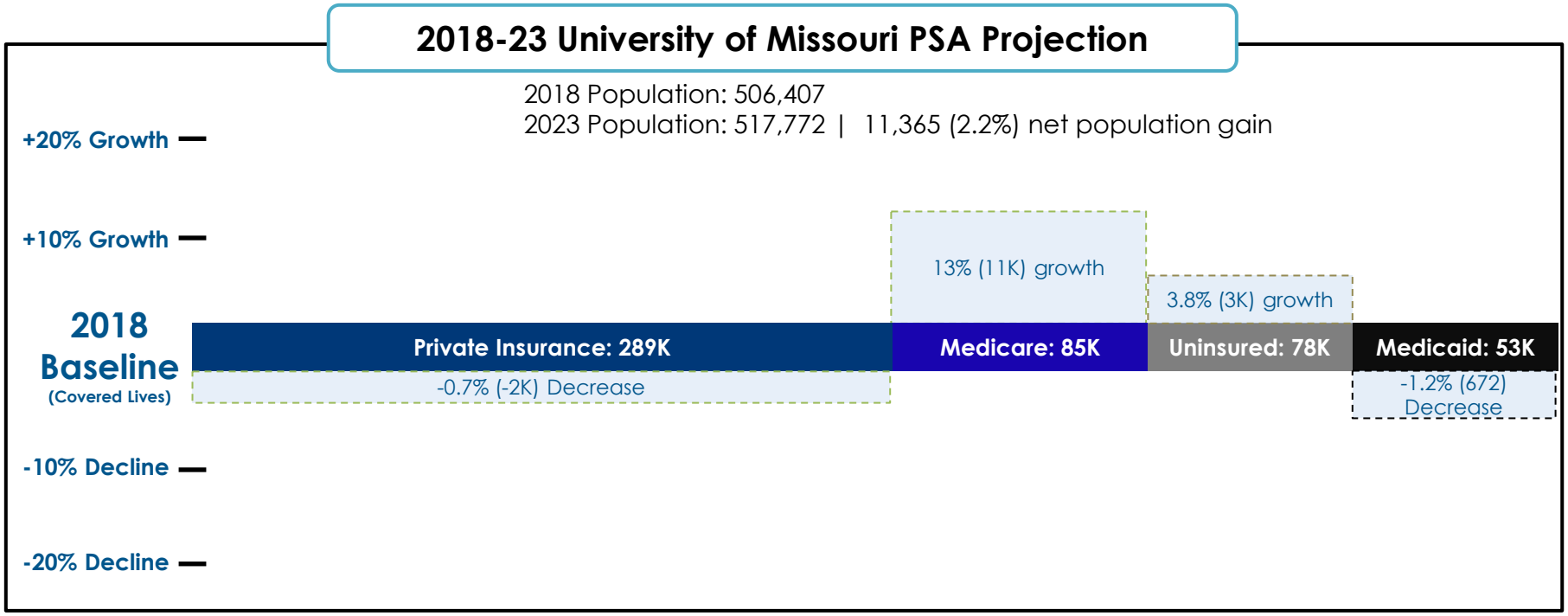


Age Group	2018	2023	Change	5-Yr % Change
0-17	107,515	108,469	954	0.9%
18-34	135,890	134,651	-1,239	-0.9%
35-54	118,035	118,768	733	0.6%
55-64	64,253	62,982	-1,271	-2.0%
65+	80,714	92,902	12,188	15.1%
Total	**506,407**	**517,772**	**11,365**	**2.2%**

As Missouri's elderly population increasingly utilizes more medical services, which are reimbursed at a lower rate through government payors, **MU Health can expect increased demand at lower reimbursement levels**

Source: Truven

Payor Mix projections for MU Health's PSA



- The share of commercial payors is shrinking; as the share of government payors is growing, lower reimbursement levels will cause further margin pressures
- Lower reimbursement rates necessitates that hospital systems become more efficient in the delivery of quality care and lower cost

Source: Truven

How is your faculty practice preparing for value-based care and population health?

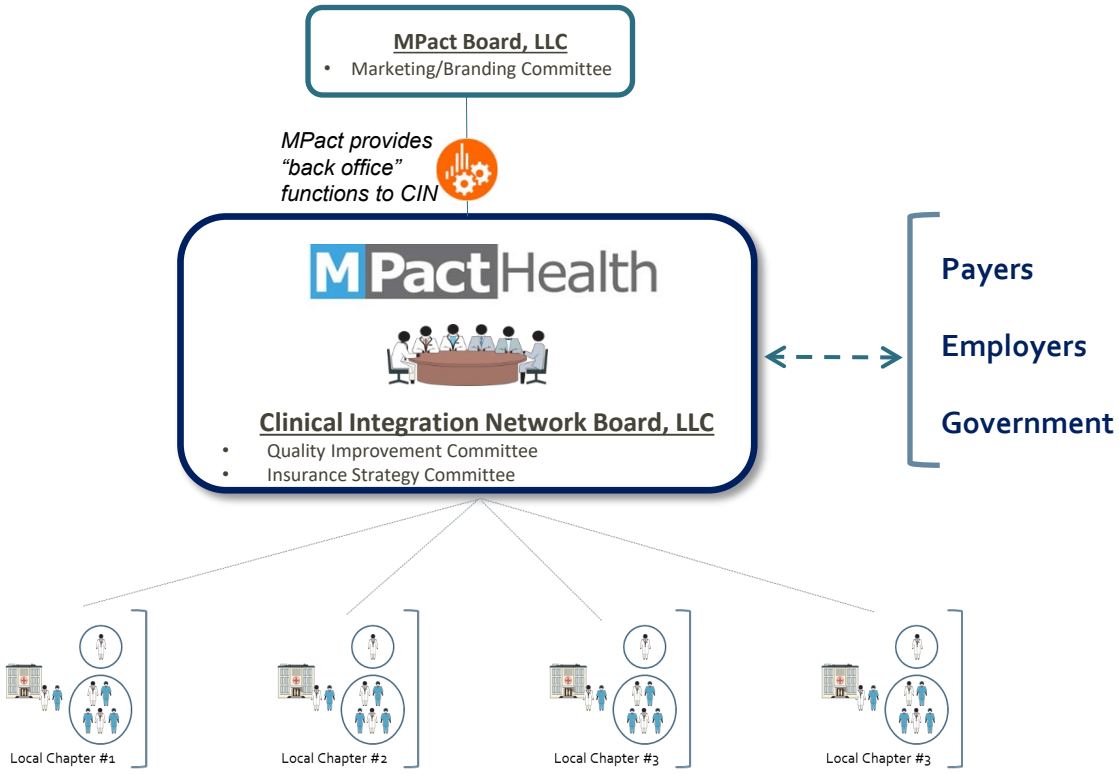
- Practice Plan, Dean's Office and Hospital leadership have held multiple communication sessions with physician leadership to educate on VBC contracts.
- Practice Plan leadership participates with hospital staff in a regular value based care preparation meeting series where all aspects of VBC issues are reviewed and measured to make sure what we are doing really has value.
- Practice plan has expanded UM, contracts, quality, analytics and related staff to ensure we are staying ahead of the issue
- We are actively involved in the full activation of a CIN Chapter as part of our overall CIN participation – many faculty involved.

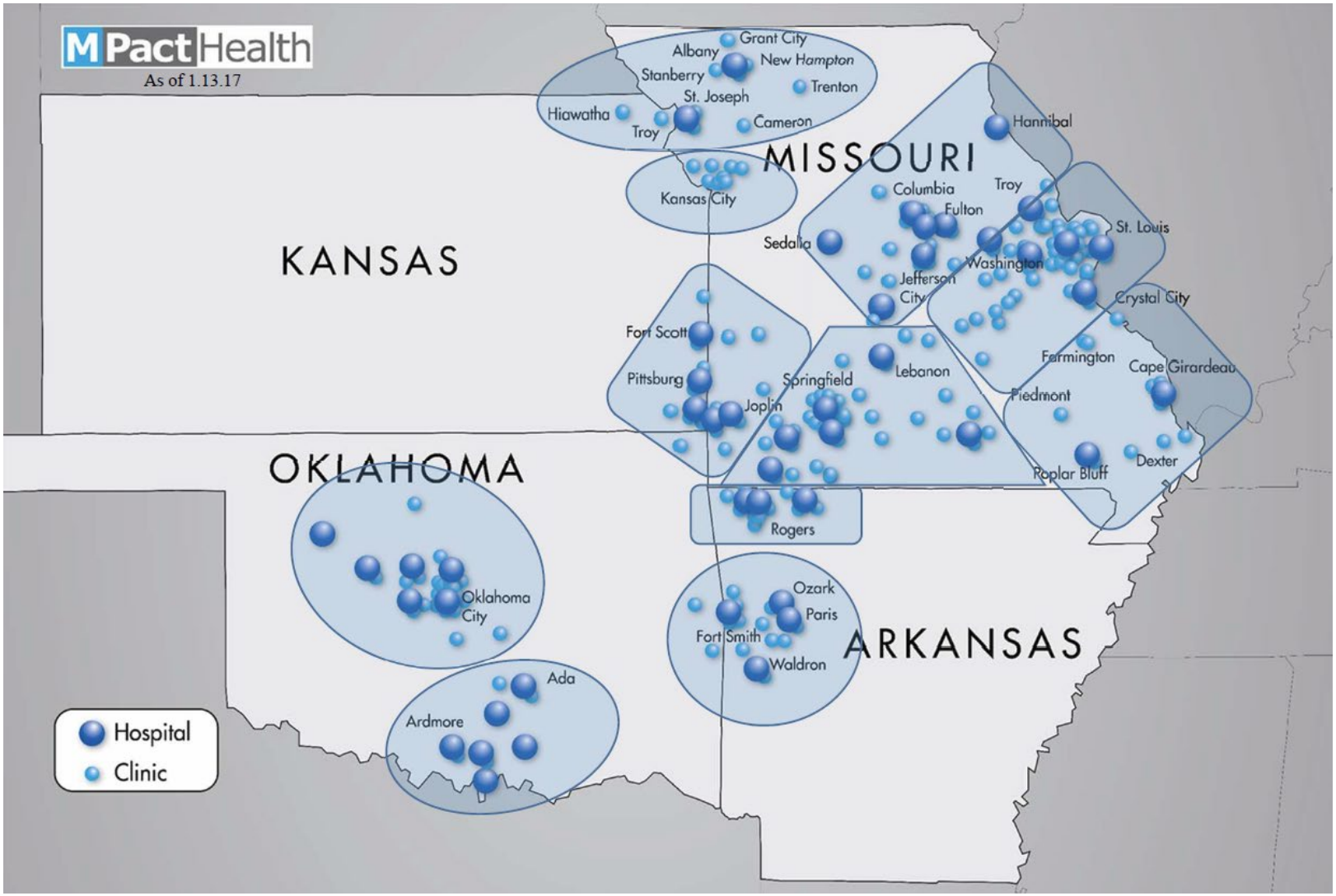
Do you participate in or own a Clinically Integrated Network (CIN)? How is it structured?

We are a member of MPACT Health – a multi-state CIN

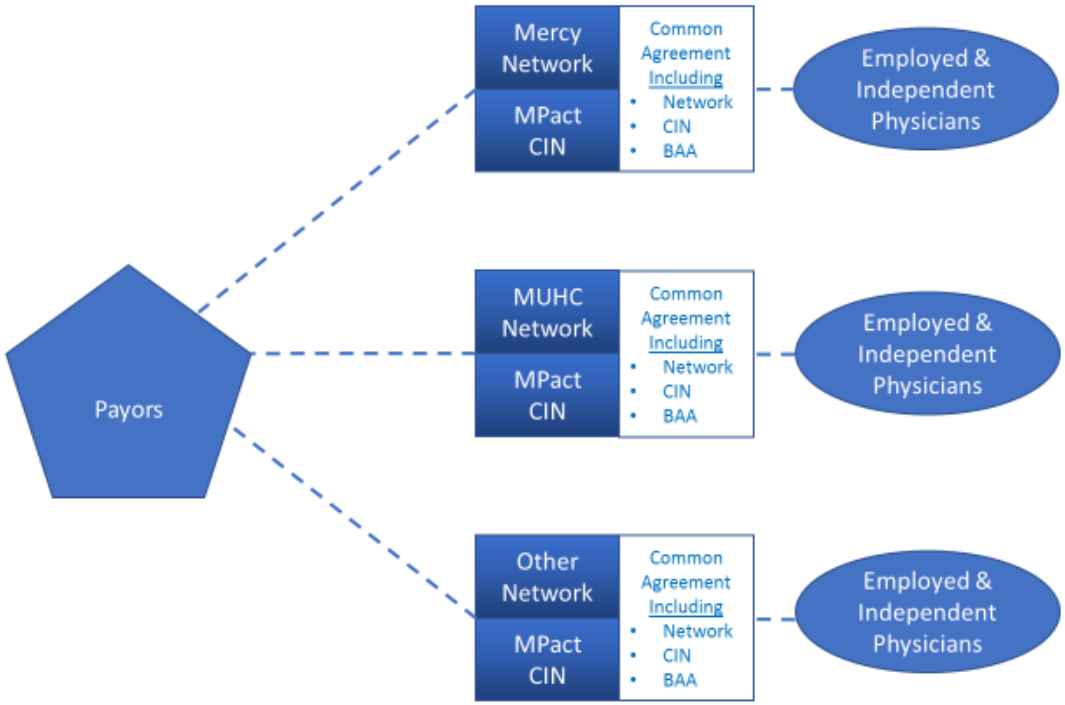
- Multi-state Clinically Integrated Network (CIN)
- Meets the FTC and DOJ definitions of clinical integration.
- Single-signature value-based contracting
- "Chapter-Centric" CIN

Organizational Structure




MPactHealth
As of 1.13.17
Grant City
Albany
New Hampton
Stanberry
Trenton
St. Joseph
Hiawatha
Troy
Cameron
Hannibal
MISSOURI
Kansas City
Columbia
Troy
Fulton
St. Louis
Sedalia
Washington
Jefferson City
Crystal City
KANSAS
Fort Scott
Farmington
Pittsburg
Springfield
Lebanon
Cape Girardeau
Joplin
Piedmont
Dexter
Poplar Bluff
OKLAHOMA
Rogers
Oklahoma City
Ozark
Paris
Fort Smith
ARKANSAS
Waldron
Ada
Ardmore
Hospital
Clinic

Contracting Model



MPactHealth

How important are these initiatives to the overall strategic direction of the practice?

- We think of the CIN and Value Based Care initiatives as our 3 – 5 year future.
- We do however, recognize the importance of working through our FFS contracts and making sure we continue to do well as long as we are able.
- FPP is transitioning from a group of equals to a medical group practice this is part of that change.

Does your practice participate in an Accountable Care Organization(s)? Describe the model(s) and your practice's level of participation.

- We have chosen not to participate in ACO's with Medicare – so far – looking at Lumeris' MA platform but too early to tell if this is viable.

What is your practice's stance on MACRA and other Medicare initiatives in this area.

- UP Total MIPS Score 93.1 points*

Category	% Weight	UP Points
Quality	60%	53.1
Cost	0%	NA
IA	15%	15
ACI	25%	25
	100%	**93.1**

* Does not include the readmission measure – calculated by CMS

Improvement Activities [IA]

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- UP received all points for IA submission [15 points]
- Patient Centered Medical Home [PCMH] Attestation – ALL POINTS
  - Changing for 2018 – PCMH for group to receive full credit as PCMH under the improvement activities performance category, at least 50% of the practice sites within the TIN must be recognized as PCMH
- 2018 IA Opportunities
  - Provide 24/7 Access to MIPS Eligible Clinicians or Groups Who Have Real-Time Access to Patient's Medical Record
  - Collection and use of patient experience and satisfaction data on access
  - Engagement of patients through implementation of improvements in patient portal

Advancing Care Information [ACI]

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- UP received all points for ACI submission [25 points]
- Formally called Meaningful Use

- 2017 ACI Transition Measures [we are currently at Stage 2]
- Base Score
  - E-prescribing
  - Security risk analysis
  - Provide patient access
  - Sending Electronic Summary of Care
- Optional Performance Measures
  - Immunization Registry Reporting
  - Patient Specific Education
  - Secure Messaging
  - View, Download, or Transmit
  - Medication Reconciliation
- Additional Registry Bonus
  - Specialized Registry Reporting

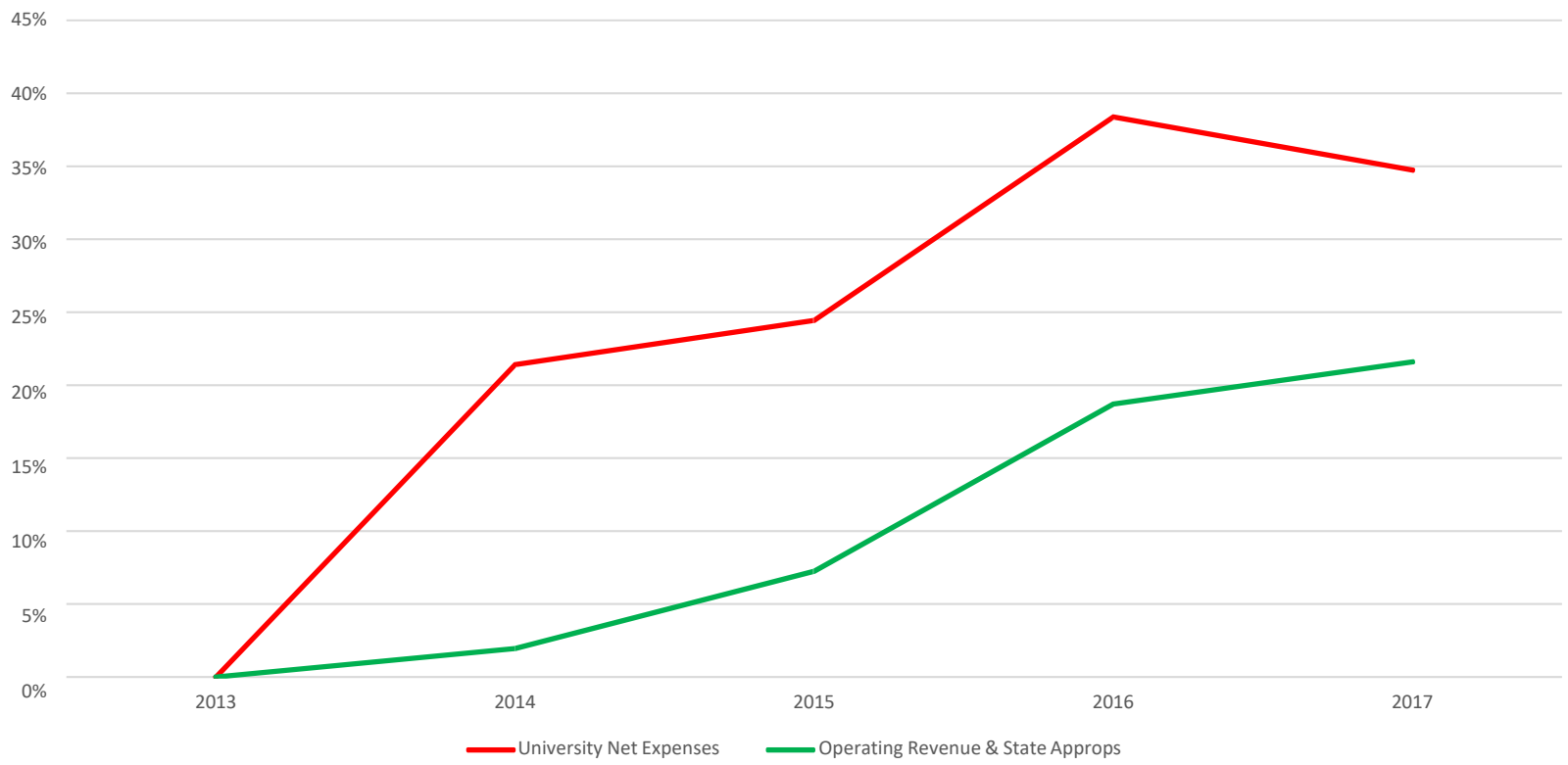
Can you identify specific successes or unique areas of focus within your practice that highlight engagement by your faculty/leadership in managing at-risk populations.

- Family & Community Medicine have successfully managed a Medicaid patient home that is a capitation arrangement
- Missouri Custom insurance product has generated savings and upside incentive payments for university employees
- Anthem EPO (new) has been sold through brokers and we have our first 2 (small) employer clients – full risk

Has your institution established data sets, dashboards and/or metrics to achieve success in managing an at-risk population(s)?

- Yes – but this is still VERY early
  - Cerner HealtheIntent
  - Mercy Epic Data Analytics
  - Partnership with UM System HR (see next slides)
- Main focus on metrics

Cost of Care is not Sustainable



Potential Cost Savings

ER Visits

199

per 1,000

24% could be redirected

Avg. cost $1,159

Top ER Visits per 1,000

12.4 Upper Respiratory Infections

10 Abdominal Pain

8.6 Nonspecific Chest Pain

Urgent Care Visits

66.7

per 1,000

Avg. cost $74

Convenience Care

12.7

per 1,000

Avg. Cost $70

University of Missouri System

COLUMBIA | KANSAS CITY | ROLLA | ST.LOUIS

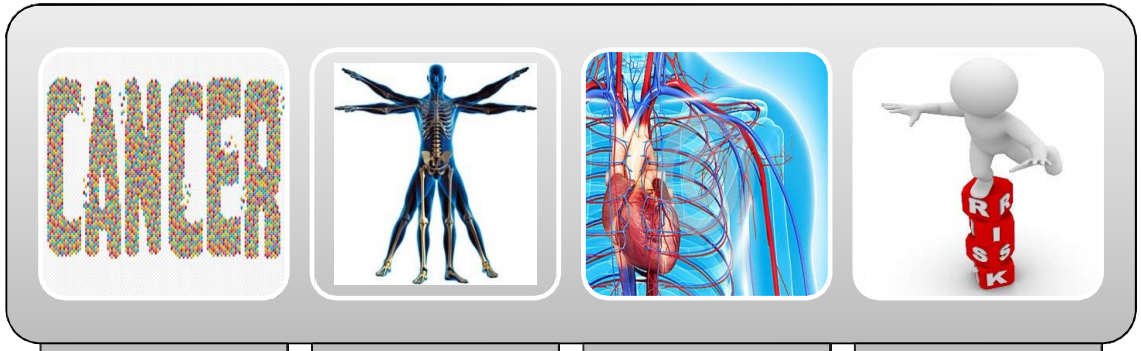
URGENT CARE CLINIC

UMSYSTEM.EDU

Medical Conditions to Peers

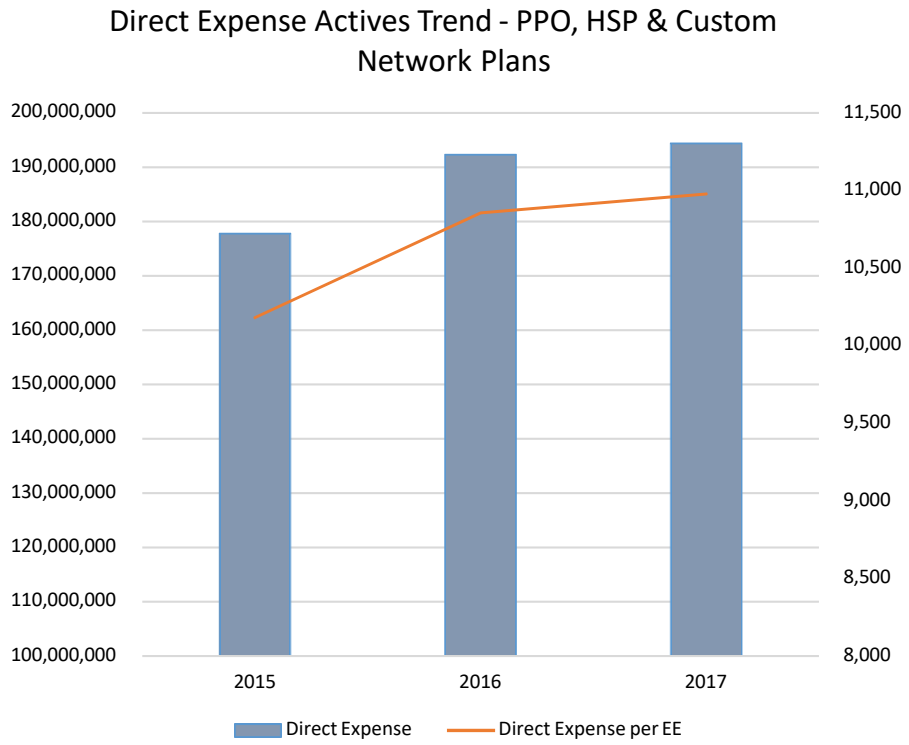
Claimants per 1000 by Diagnosis Network	Norm PPO		Custom HSP	
Infectious and Parasitic Diseases	427.69	337.44	363.18	294.27
Respiratory System	328.86	**386.87**	**381.46**	273.81
Musculoskeletal System	266.78	**328.17**	**326.00**	220.97
Circulatory System	170.09	146.07	**204.44**	103.89
Mental Diseases and Disorders	155.24	**161.59**	**162.38**	107.37
Neoplasms	135.42	84.21	130.88	74.68
Digestive System	128.12	**133.95**	**146.67**	89.34
Pregnancy and Childbirth	61.03	**77.62**	51.55	**63.07**
Perinatal Period	22.66	**31.89**	20.59	20.36

Top 3 Medical Cost Drivers



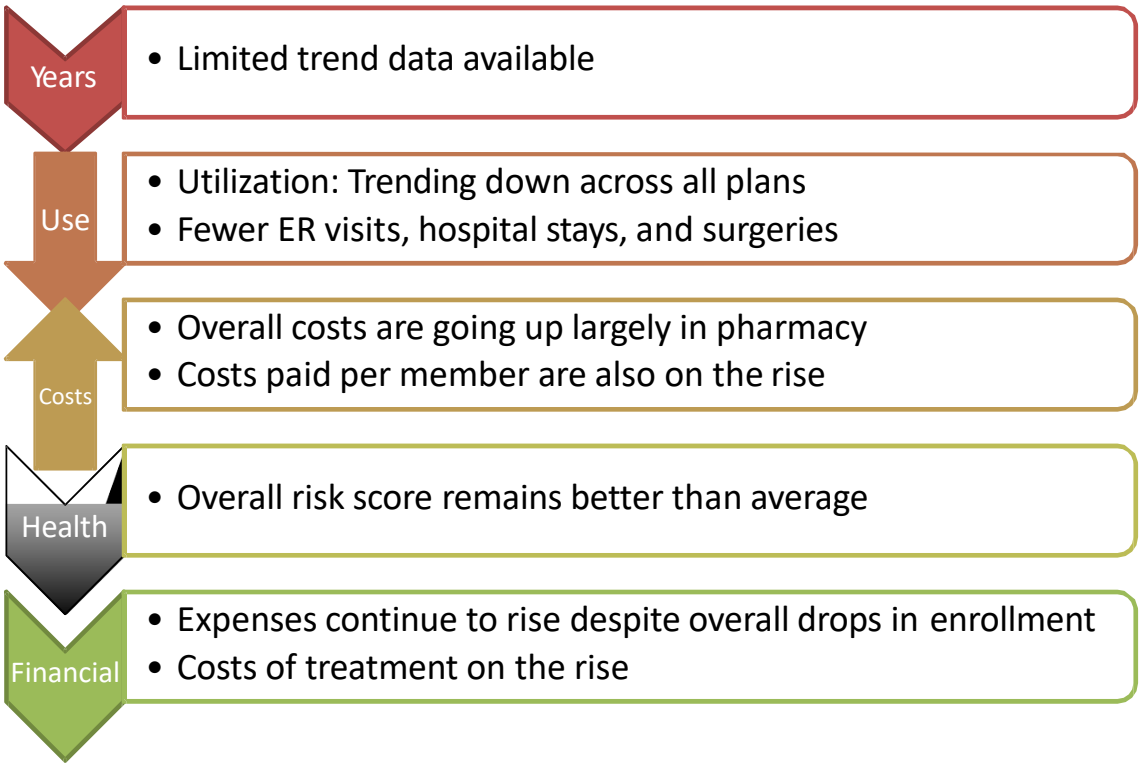
Cancer	Musculoskeletal	Circulatory	24% of members are at risk
13% of spend	12% of spend	8% of spend	20% Chronic
10% of members	30% of members	15% of members	3% Complex
PMPM $41	PMPM $40	PMPM $26	

Direct Expenses Trend



- 2015: Custom Network Added
- 2016: Move to United Health Care; Tobacco Discount Started
- 2017: St Louis Custom Network began

Observations



What other strategic factors are guiding your decisions and investments in value-based care and population health?

- VBC has been slow to come to the market here but our partners (Mercy) are moving rapidly to take on ever larger components of care.
- Managed Medicaid is growing rapidly but in the face of budget constraints that mean we need to focus on cost

Please comment on any other items that are guiding your deliberations and actions in this area.

- Overall partnership with hospital – how close?
- Need to go deeper on managing cost (Strata cost accounting conversion)
- The practice plan has to be part of the solution as they are the ones that can actually address cost of care issues.