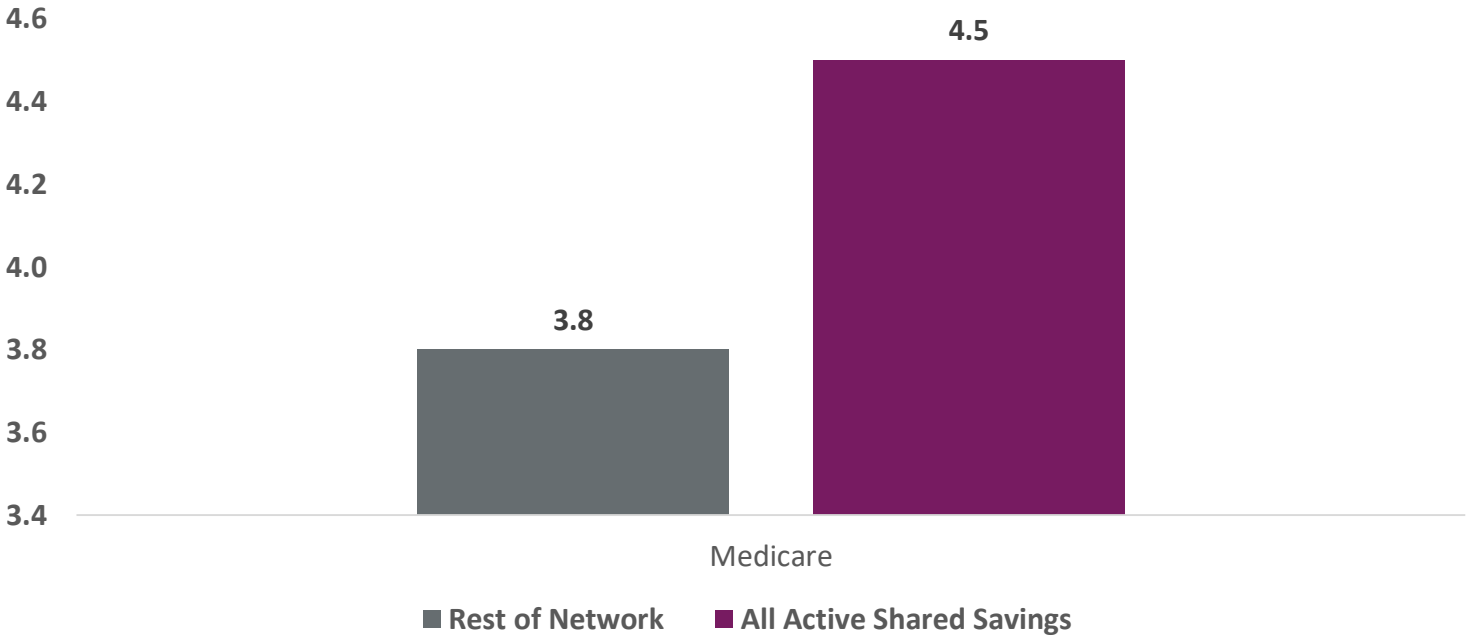
Value-Based Payment Strategies
ACAP CEO Summit
June 21, 2019

UPMC LIFE CHANGING MEDICINE

CY 2018 Medicare Star Rating
Shared Savings Program v Rest of Network
Claims paid through February 28, 2019



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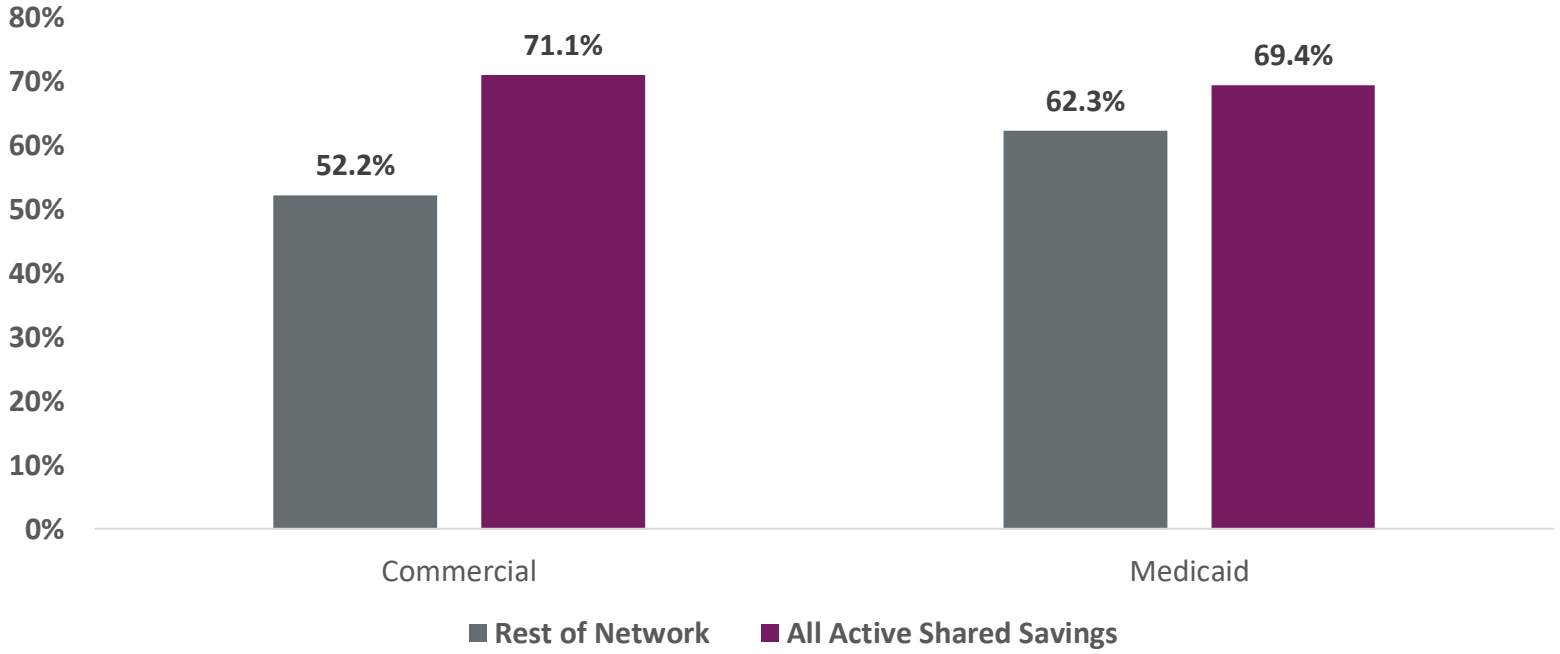
CY 2018 HEDIS Gap Closure Rate
Shared Savings Program v Rest of Network
Claims paid through February 28, 2019



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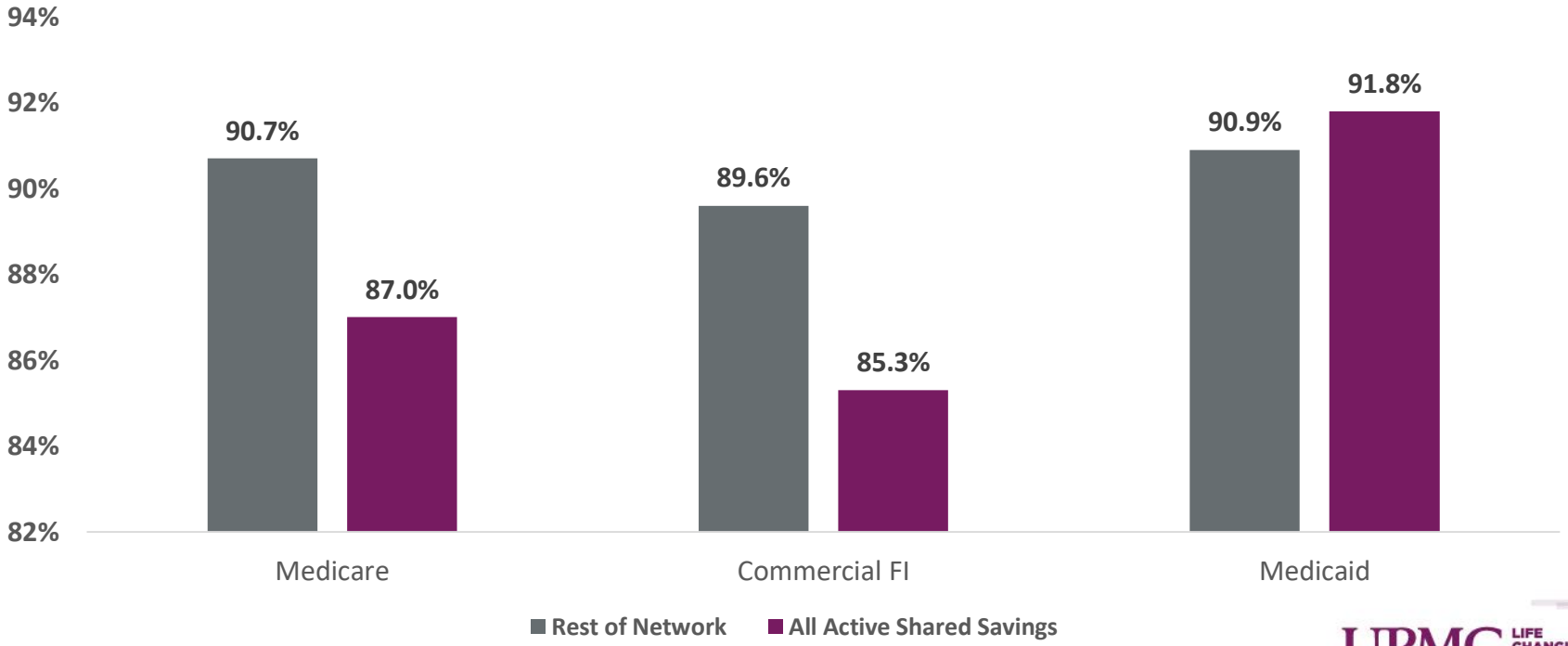
CY 2018 Medical Expense Ratio
Shared Savings Program v Rest of Network
Claims paid through April 30, 2019



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2019 Gain Share Program


Identify Care Coordination Opportunities
Identify Open Gaps
Referral to Health Plan Programs

2019 is the Year of Quality

Strong focus on Medicare/SNP quality through the movement to predicted CMS Stars cut points methodology to drive continuous improvement

- Resulted in modification of sliding scale to account for adjusted scores

Additional bonus opportunities in Medicare/SNP measures

- Breast Cancer Screening
- Colorectal Cancer Screening
- Plan All Cause Readmissions

Quality sliding scales remain in all lines of business to offer larger gain distributions as quality increases

Pennsylvania Pediatric Healthcare Network Partnership

- PPHN participants aggregated together for purposes of target setting and results for the first time in 2019
  - CCP, GAP, Kids Plus, Pediatric Alliance
  - Pediatrics South tentative addition for 2020
- Total Cost of Care (TCOC) structure for Medicaid and Commercial decreases the total amount of gains possible
- Additional incentive dollars achievable through targeted bonus measures (3 for Commercial, 5 for Medicaid)

The Cost of Depression

- Depression in the U.S. costs $210 billion per year, yet only 40 percent of this sum is associated with depression itself.
- Most of the costs are for related mental illnesses, such as anxiety and PTSD, and chronic physical health conditions
- For every $1.00 spent treating depression, another:
  - $4.70 is spent on direct and indirect costs of related illnesses and
  - $1.90 is spent on reduced productivity and economic costs associated with suicide directly linked to depression.

Greenberg PE et al. The economic burden of adults with major depressive disorder in the United States (2005 and 2010). The Journal of Clinical Psychiatry, 2015 Feb;76(2):155-62. doi: 10.4088/JCP.14m0929

Depression Screening is a Billable Service

The Health Plan covers depression screening across all products.

HCPCS Code G0444

- Annual Depression Screening
- 15-min. time requirement waived
- Reimbursed at fee schedule rates EOB generated (except Medicaid)

HCPCS Reporting Codes

- **G8431** – depression screening positive and plan established
- **G8510** – depression screening negative
- No reimbursement & no EOB

G0444 Fee Schedule:

- ❖ Commercial and CHIP = $15.30
- ❖ Medicare and SNP = $17.42
- ❖ Medicaid = $12.24

No Reimbursement

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Shared Savings Incentive for Depression Screening

- An ***annual incentive bonus for depression screening*** is paid to the Shared Savings Partner if the following percentages of its UPMC Health Plan members ages 18 and older, are screened for depression:
  - ***$2.00 per member if 25% are screened***
  - ***$5.00 per member if 50% or more are screened***

The incentive is paid per unique member screened, not the entire membership

- Percentage of members screened is determined by:
  - The total number of codes submitted:
    - G0444 (with or without a modifier), G8510 and G8431
  - Divided by the average UPMC HP membership for the Shared Savings Partner (ages 18 years and older) across all lines of business.

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Population Health Data

Population Data: Unplanned Care Use

Members with:	Active Members	% of Active Members
At least one inpatient admission via ER	985	6%
At least one observation admission	597	3%
At least one ER visit	3,058	17%
At least one urgent care visit	3,467	20%
4+ acute IP admissions and 4+ ER visits	5	0%
Any unplanned, emergent care	6,392	37%
Greater than 70% unplanned care	1,098	6%

- Site specific reports list individual members in each category

Population Data: Complex Care Coordination Opportunities

Members with:	Active Members	% of Active members
Multiple Sclerosis	31	0%
Inflammatory Bowel Disease	215	1%
SPMI and Comorbid Chronic Conditions	1,808	10%

- Site specific reports list individual members in each category

Population Data: Care Need Index (CNI) Range

Care Need Index Range	Active Members	% of Active Members
0 – 0.75	8,252	47%
1.0 – 1.75	4,809	27%
2.0 – 2.75	2,969	17%
3.0 – 3.75	885	5%
4.0 – 4.75	383	2%
5.0	162	1%

- CNI is a predictive Risk Score that enables rapid stratification of high-risk members into groups to improve care and reduce costs
- It is comprised of 4 categories of information:
  - Predictive Score: 30-40%
  - Diagnosis Resource Intensity: 20-30%
  - Avoidable Event Utilization: 20-25%
  - Gaps in Care: 15-20%

Population Data: Site Specific Clinical Reports – From Population to Personal

Patient Name	Urgent Care	ED	Obs.	IP	>70% un-planned	4 IP + 4 ED	7 Drs. + 7 meds	SMI + PH	High risk meds	Warfarin w/o INR	CNI Score	HEDIS Metrics					
ABCD	2	5	2	4	X	X	X	X		X	4.5	X	X	X	X		X
EFGH	1	3	3	1	X		X		X	X	3.5		X	X	X		
IJKL	0	8	0	0	X			X	X		2.0	X	X	X	X	X	X
MNOP	0	0	0	2							1.5						
QRST	3	2	0	1		X			X		1.0					X	
UVW	0	1	0	0							1.0						
XYZ	0	0	0	0							0.5		X		X		

Quality Reports

Quality Report: Gap Closure Rate

UPMC *for You* Medicaid Patients				
	HEDIS Composite Score		Annual Dental Visit 2-21	
Site	Denominator	Rate	Denominator	Rate
ACME Pediatric Group	8289	48.4%	4397	44.0%
Office A	1111	44.5%	613	39.0%
Office B	874	42.5%	465	40.0%
Office C	1675	54.0%	836	49.0%
Office D	613	52.7%	315	50.0%

- Data are provided for composite HEDIS scores and for each individual HEDIS metric
- Denominators and rates are provided for the overall group and each individual office site

Quality Gap Reports - Number Needed to Achieve Next Level

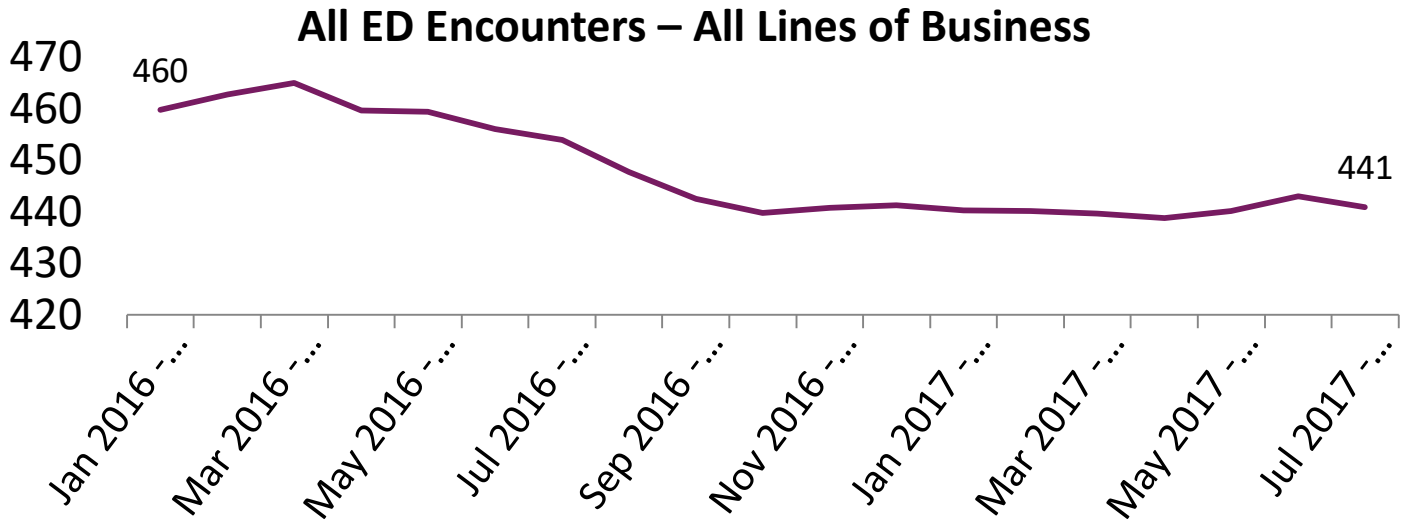
Metrics	Denominator	Current Closure Rate	Gaps to Gain 50th percentile	Gaps to gain 90th percentile	Gaps to gain 90th percentile
Adolescent Well Visits 2-21	6,000	64.2%	702	780	840

- This information can support an intelligent action plan:
  - Focus on metrics where there is need to improve
  - Focus on metrics where there is greatest likelihood to achieve the next HEDIS percentile

Ad Hoc Reports

Monthly Results – Rolling 12 Month Analysis

Claims Incurred Through July 31, 2018 and Paid Through August 31, 2018



- ED Encounters per 1,000 decreased 4.1% from CY 2016 to the current period.

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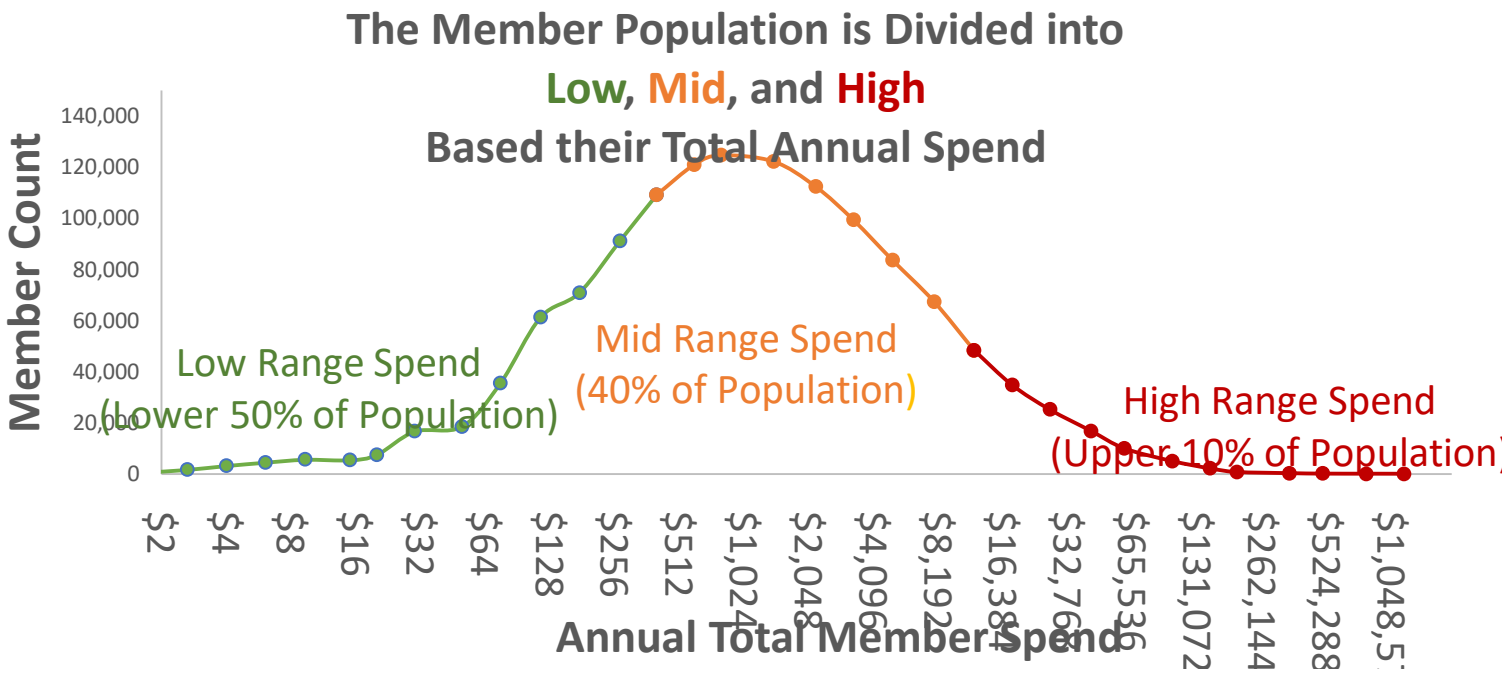
Predictive Expenditure Model

- Predictive Expenditure Model of emerging risk patients
- Modeled using 12 months of claims data updated monthly.
- Members are divided into three cost categories:
  - Low Spend (least expensive 50%)
  - Mid (50% - 90% most expensive)
  - High (90% - 100% most expensive)
- Through historical modeling, the PEM has shown reasonable predictive power in identifying members moving from the Mid range to the High range.

Predictive Expenditure Model



- A list with the members predicted to move from the Mid range to the High range is provided.

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Objectives for 2020 Gain Share Program

2020 Gain Share Program Objectives

- Continue the focus on bonus measures important to the Medicare Stars rating and Medicaid MCO P4P performance
  - Increases the focus on the Medicaid LOB by allowing achievement of Medicaid quality bonus dollars
- Add requirements around the use of the Care Coordination Fee to drive engagement and focused use of the dollars
- Expand the depression screening incentive to a wider population and ensure that screenings are supported by appropriate care coordination and follow up activities

Types of Reports Provided to the PCMH Practices

1) **Membership Data**
2) **Monthly Financial Reports:**
   - Trended Income Statements – Current gainshare status compared to the previous year
   - Profit and Loss statements – Shows MER (Costs ÷ Revenue); identifies areas of opportunity
     Facility and Provider Leakage Reports – Key hospitals, ancillary facilities, and specialists where the majority of money is being sent; are they out of your network?
   - CDPS Reports (Chronic Illness and Disability Payment System - Risk-Adjustment Model):
     - Measures morbidity, especially important for the chronically ill, disabled Medicaid population – relevant to enhancing revenue similar to HCCs in Medicare

2) Key Performance Indicators: Utilization metrics compared to benchmarks

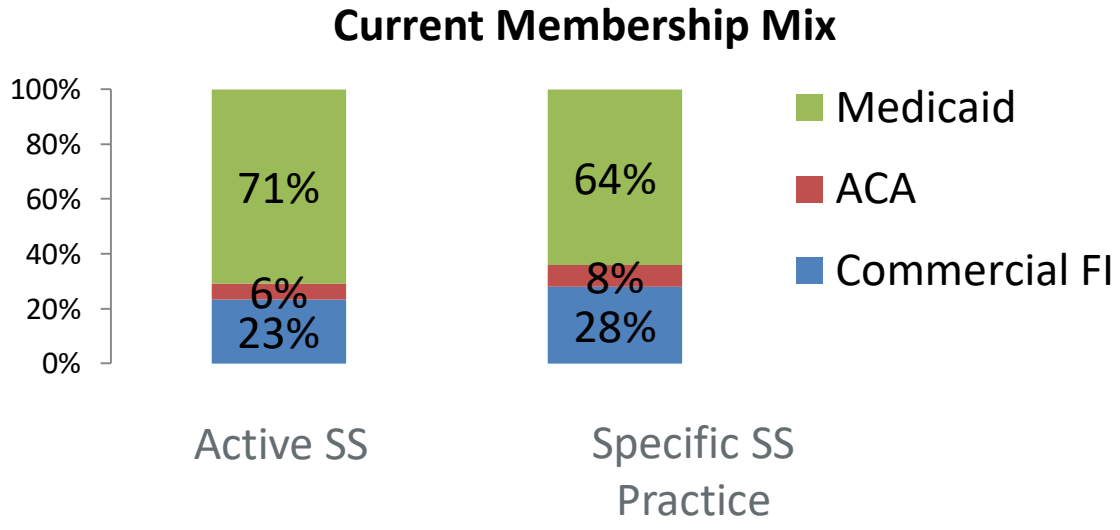
3) Population-Health, clinical actionable reports: Key Performance Indicators, Complex, Unplanned, Uncoordinated care, PH/BH, high-cost, emerging-risk patients, and Coumadin ϕ INR

4) Quality Reports: Overall and member-specific gap information for relevant HEDIS / P4P metrics

5) Ad hoc reports

Membership Information

LOB	Jan 2016 - Dec 2016	Jul 2017 - Jun 2018	% Change
Commercial FI	14,765	16,449	11%
ACA	3,728	4,698	26%
Medicaid	33,469	37,902	13%
TOTAL	**51,972**	**59,059**	**14%**



Key Performance Indicators

- Data displayed by SS Group and individual office sites
- Benchmark comparisons include:
  - All active Shared Savings groups
  - 75% Milliman Benchmark for Pittsburgh
- Data elements include:
  - Average membership
  - PMPM and Utilization Rate / 1000 for:
    - Inpatient Admissions
    - Observations
    - Emergency Room Visits
    - Urgent Care Visits
    - Primary care Visits
    - Specialist Visits
    - Brand Pharmacy Prescriptions
    - Generic Pharmacy Prescriptions

UPMC Medicaid Members

ABC-SS	Average Monthly Membership				Shared Savings Medical Expense Ratio			Shared Savings Medical Expense		
Office	2017	YTD 2018	Actual Change	% Change	2017	YTD 2018	Actual Change	2017	YTD 2018	Actual Change
1	122,478	132,029	9,551	7.8%	88.5%	93.8%	5.3%	$ 433.70	$ 446.97	3.1%
2	3,581	3,401	(180)	(5.0%)	88.3%	89.6%	1.3%	$ 412.61	$ 430.29	4.3%
3	548	481	(67)	(12.2%)	72.9%	78.8%	5.9%	$ 315.08	$ 352.06	11.7%
4	499	448	(51)	(10.2%)	79.7%	74.2%	(5.5%)	$ 345.59	$ 325.23	(5.9%)
5	374	389	15	4.0%	81.6%	91.2%	9.6%	$ 348.39	$ 397.74	14.2%
	278	320	42	15.1%	115.3%	127.4%	12.1%	$ 599.21	$ 654.40	9.2%
	310	280	(30)	(9.7%)	82.0%	76.3%	(5.8%)	$ 384.28	$ 366.20	(4.7%)
	252	227	(25)	(9.9%)	104.4%	87.6%	(16.8%)	$ 483.76	$ 418.33	(13.5%)
	210	199	(11)	(5.2%)	88.3%	112.1%	23.8%	$ 461.95	$ 579.93	25.5%
	207	168	(39)	(18.8%)	75.7%	72.8%	(2.9%)	$ 384.87	$ 381.66	(0.8%)
	179	144	(35)	(19.6%)	101.8%	89.0%	(12.8%)	$ 473.97	$ 418.92	(11.6%)
	147	128	(19)	(12.9%)	88.2%	111.8%	23.6%	$ 362.12	$ 428.39	18.3%
	127	122	(5)	(3.9%)	99.6%	88.4%	(11.2%)	$ 526.00	$ 442.04	(16.0%)
	123	116	(7)	(5.7%)	72.8%	80.8%	8.0%	$ 335.25	$ 422.93	26.2%
	102	111	9	8.8%	130.1%	117.8%	(12.3%)	$ 696.57	$ 635.24	(8.8%)
	127	108	(19)	(15.0%)	76.3%	87.9%	11.6%	$ 378.42	$ 473.28	25.1%
	0	87	87	0.0%	0.0%	69.5%	69.5%	$ -	$ 421.71	0.0%
	68	69	1	1.5%	94.8%	77.4%	(17.4%)	$ 541.46	$ 471.15	(13.0%)
	13	9	(4)	(30.8%)	28.3%	15.6%	(12.6%)	$ 92.03	$ 68.09	(26.0%)
	25	0	(25)	(100.0%)	132.1%	0.0%	(132.1%)	$ 709.50	$ -	(100.0%)

Preview of Coming Attractions

- OB P4P program – will go into effect in 2019
- OB bundle for normal pregnancies – scheduled to begin in 2020
- Potential perinatal bundles for pregnant women with OUD and infants exposed to opioids: prenatal, NAS, and postpartum mother and infant (4th trimester)
- Multimodal pain management bundle for members on long-term opioid therapy for non-cancer pain
- Total Cost of Care risk model with Children's Hospital – Pediatric Care network

Center for Value-Based Pharmacy

- UPMC ‘s Center was created to evolve traditional drug pricing to more innovative value-based contracting to add more accountability, shared risk and transparency with the ultimate goal of changing the drug pricing paradigm
- UPMC has a differentiated ecosystem (payor, provider, pharmacies and data assets) to be able to leverage to lead in value-based drug contracting as opposed to traditional formulary placement rebate methodology

Current Rx Impact

- To date in our contracts we've removed cost as a barrier to drug access for the member
  - Brilinta (anti-platelet clogging) on generic tier
- Measure total cost of medical care in a VBC drug contract
  - Jardiance (treatment of diabetes)
- looked at the SUD category and align incentives between the payor and manufacturer to drive persistency in therapy
  - Vivitrol (medication assisted substance use disorder treatment)

Pharmacy Challenges

- It is challenging to get industry partners to accept significant risk. The reason typically relates to Medicaid best price concerns (where there be more at risk).
- Industry partners have reluctance to enter into agreements that include outcomes not specifically linked to the drug label. This has limited our attempts to get innovative contracts.

Coming Soon

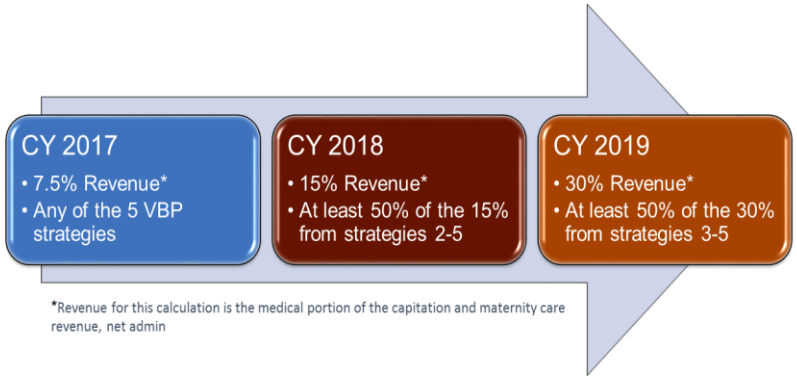
- Our next targets will involve Patient Reported Outcomes as a proxy for drug effectiveness
- Our goal is to leverage all stakeholders (pharmacies, providers, members) to be a part of these arrangements so we can achieve whole person, team- based care

Medicare and Medicaid

- Impact of Best Price is still the biggest barrier (especially in gene therapies where refunds for treatment failures if counted toward best price would not work). Hence for expensive therapies we need a waiver of Best Price in order to continue to add more risk
- The Safe Harbor removal act currently being debated does not have an allowance/waiver for VBC hence their future in Medicare is cloudy. Similar to the above we are seeking a waiver for VBCs and safe harbor.

Value Based Purchasing – Pennsylvania Requirements

DHS Requirements

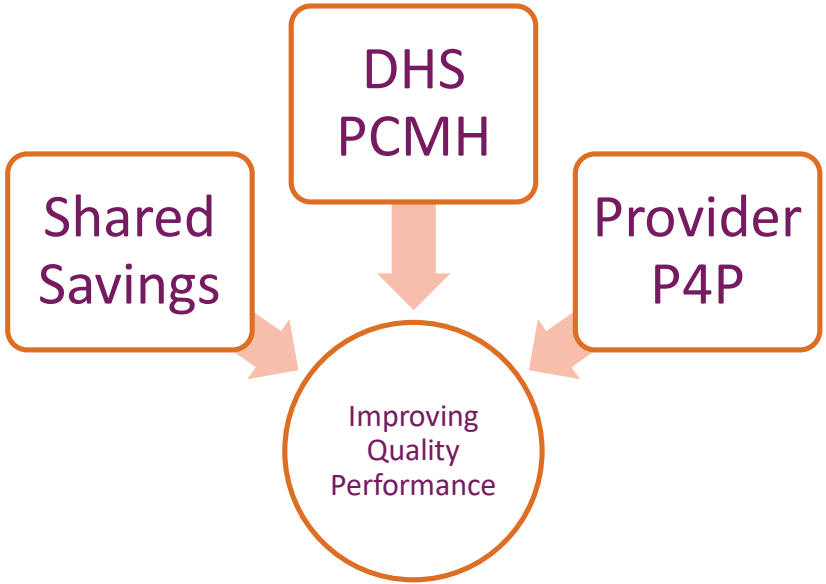


For CY 2017, UPMC *for You* was at 42.7% of revenue, well over the required 7.5%.

VBP Strategies

1. Provider pay for performance programs
2. Patient Centered Medical Homes (PCMH)
3. Shared savings contractual arrangements
4. Bundled or global payment arrangements
5. Full risk or Accountable Care Organization payment arrangements

Impact on Quality Performance



MCO P4P Measures (Key Quality Measures)

- Well-Visits in the First 15 Months of Life
- Well Child Visits in 3-6 Years of Life
- Adolescent Well Care Visits
- Frequency of Prenatal Care
- Prenatal Care in the 1st Trimester
- Postpartum Visits
- Controlling High Blood Pressure
- Diabetic A1c Poor Control
- Medication Management for People with Asthma
- Plan All Cause Readmission

Pennsylvania

- With the State move toward a Uniform Preferred Drug List (PDL), we are unclear as to whether we will have the ability to continue these contracts as we are prohibited from collecting discounts/rebates in a PDL world

Pennsylvania

- The gain share program has aided mitigating medical trends, as overall our current Medicaid trend is (0.5%). Nearly 47% of Medicaid members are in a VBP program.
- UPMC leads the way in PA Medicaid managed care in terms of percentage of medical revenue in VBP programs.

Where Are We Headed?

- We are transitioning to Total Cost of Care models, with the goal of further promoting quality within the program. We anticipate that physician groups will understand TCOC more than MER, but that the TCOC program must still address key quality metrics and be based on the TCOC to achieve a good medical expense ratio as revenue changes.

Learnings

- We have learned that with the gain share program that quality changes faster than significant improvement in the management of cost.
- Physician groups can get ahold of closing gaps. They are also able to focus on key metrics at a time, like ER or readmission rates because they can make changes in their practices that will directly impact these.