The Premier Healthcare Alliance ACO Collaboratives: From Readiness to Implementation

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Reform's "strategic" plan

Cuts to Existing [illegible]

- Market baske[illegible]
- DSH cuts
- P4P & Nonpay[illegible] for anything preventable [illegible] unnecessary

[illegible]t Existing System

- Bu[illegible]dled Payments
- [illegible]novation Center/ demonstrations
- ACOs

Reform requires paradigm shift and delivery system changes

Value-based purchasing

Accountable Care Organizations

Bundled payments

Non-payment for preventable readmissions

Non-payment for infections and HACs

Transparency initiatives

Drive to tackle waste, fraud and abuse

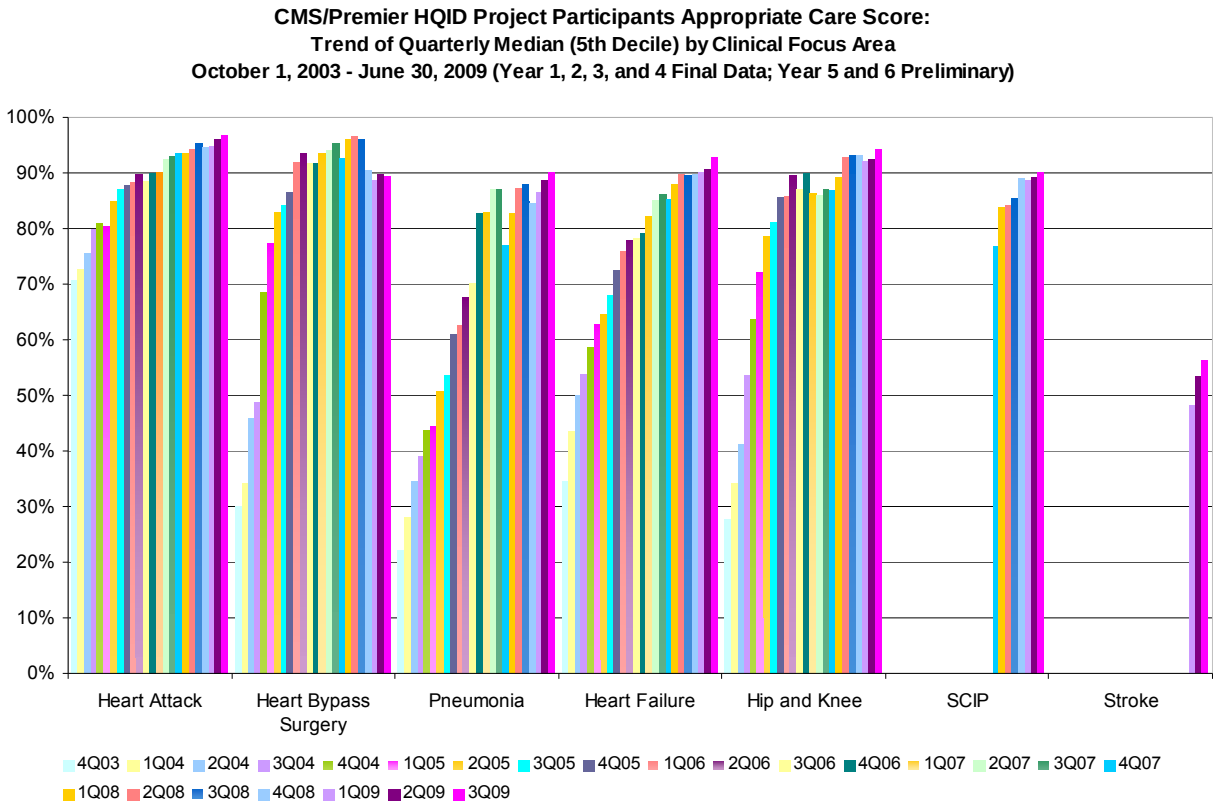
Journey to high-value healthcare

National success through HQID

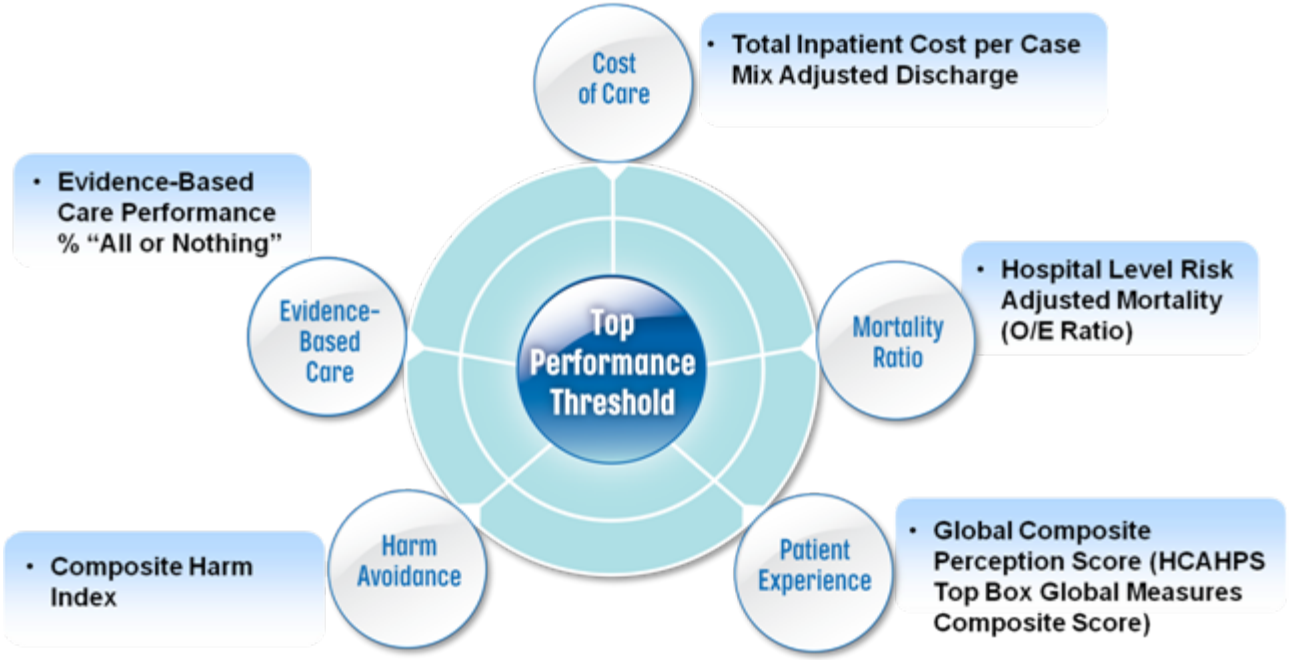
Avg. improvement from 4Q03 to 3Q09 in all clinical areas (24 quarters)
55.7%

Clinical Area	Improvement (percentage points)
Heart Attack	26.0%
Heart Bypass	59.4%
Pneumonia	68.1%
Heart Failure	58.1%
Hip & Knee	66.7%

Evidence-based Care Improvements

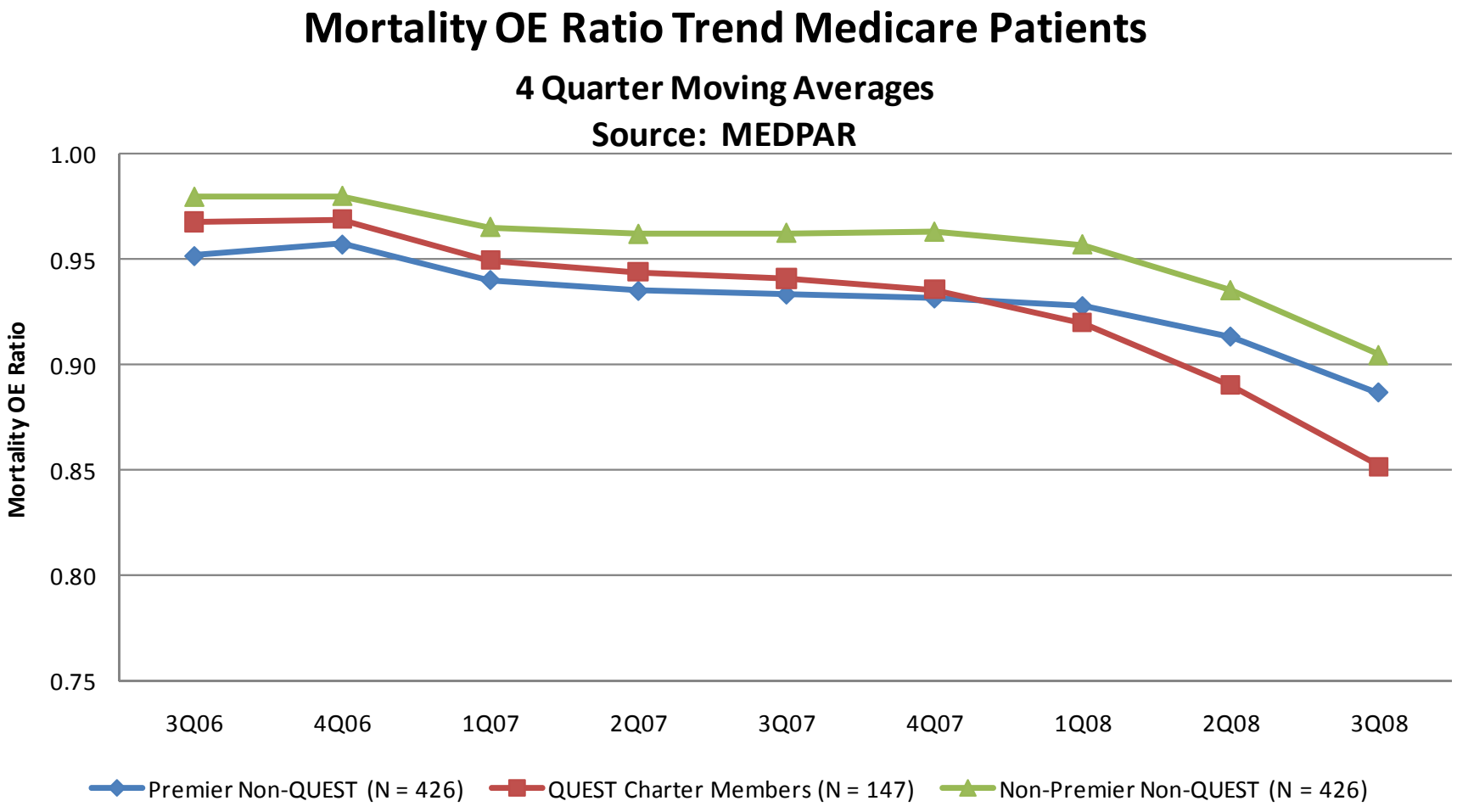


Framework for high-value healthcare yielding results



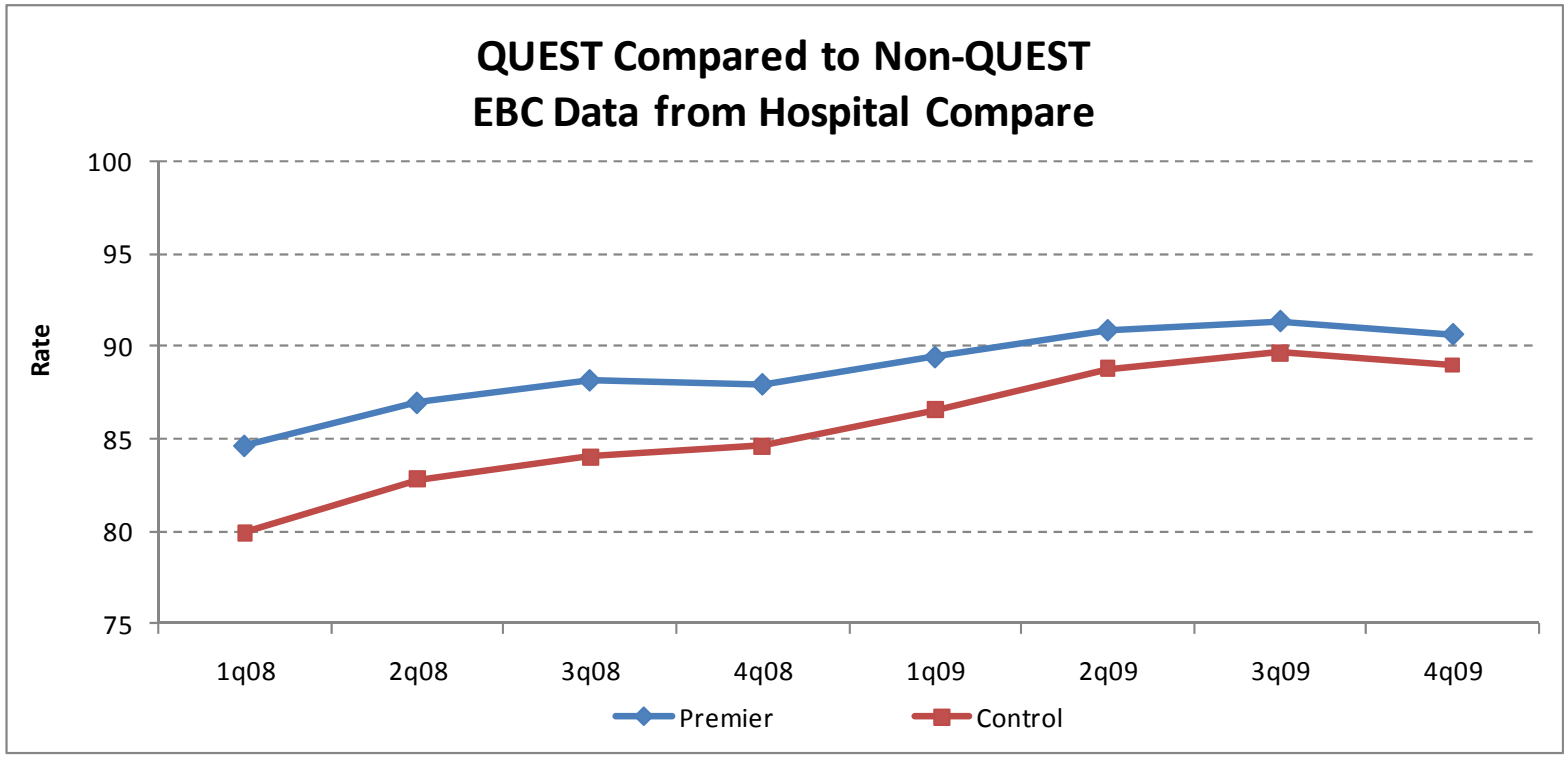
	Year 1	18 Months	Year 2
Lives saved	8,043	14,649	22,164
Dollars saved	$577M	$1.036B	$2.13B
Patients receiving EBC	24,818	41,130	43,741

Mortality trend: QUEST vs. national averages

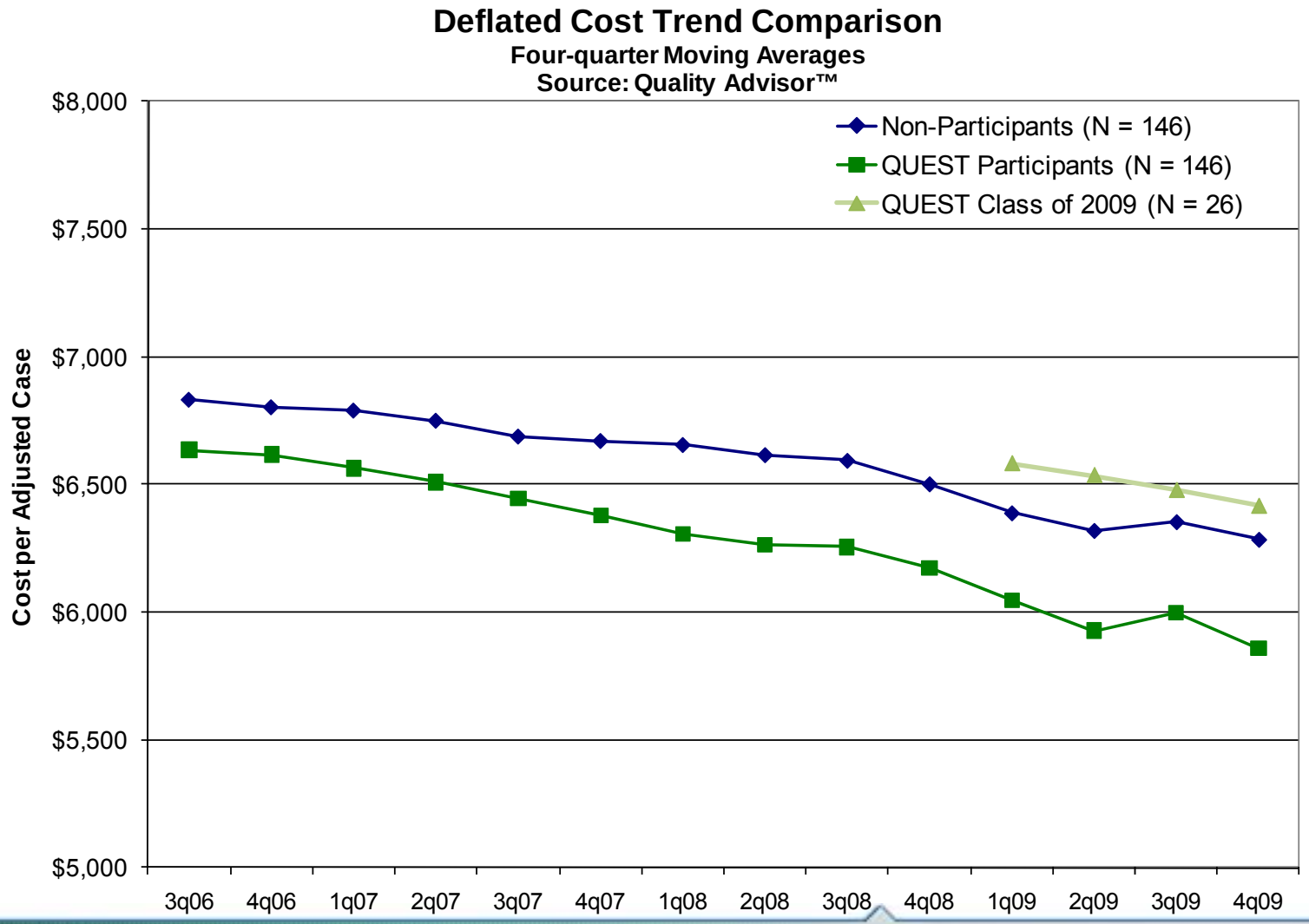


EBC trend: QUEST vs. national averages

- A comparison of QUEST hospitals against a “comparable” non-QUEST hospitals using data in the Hospital Compare Clinical Warehouse also showed the QUEST facilities started higher in EBC with non-participants catching up over time.



Cost trend: QUEST vs. non-participants



The next horizon - accountable care organizations

Payer Partners:

- Insurers
- CMS
- Employers

ACOs are easier to imagine than execute …

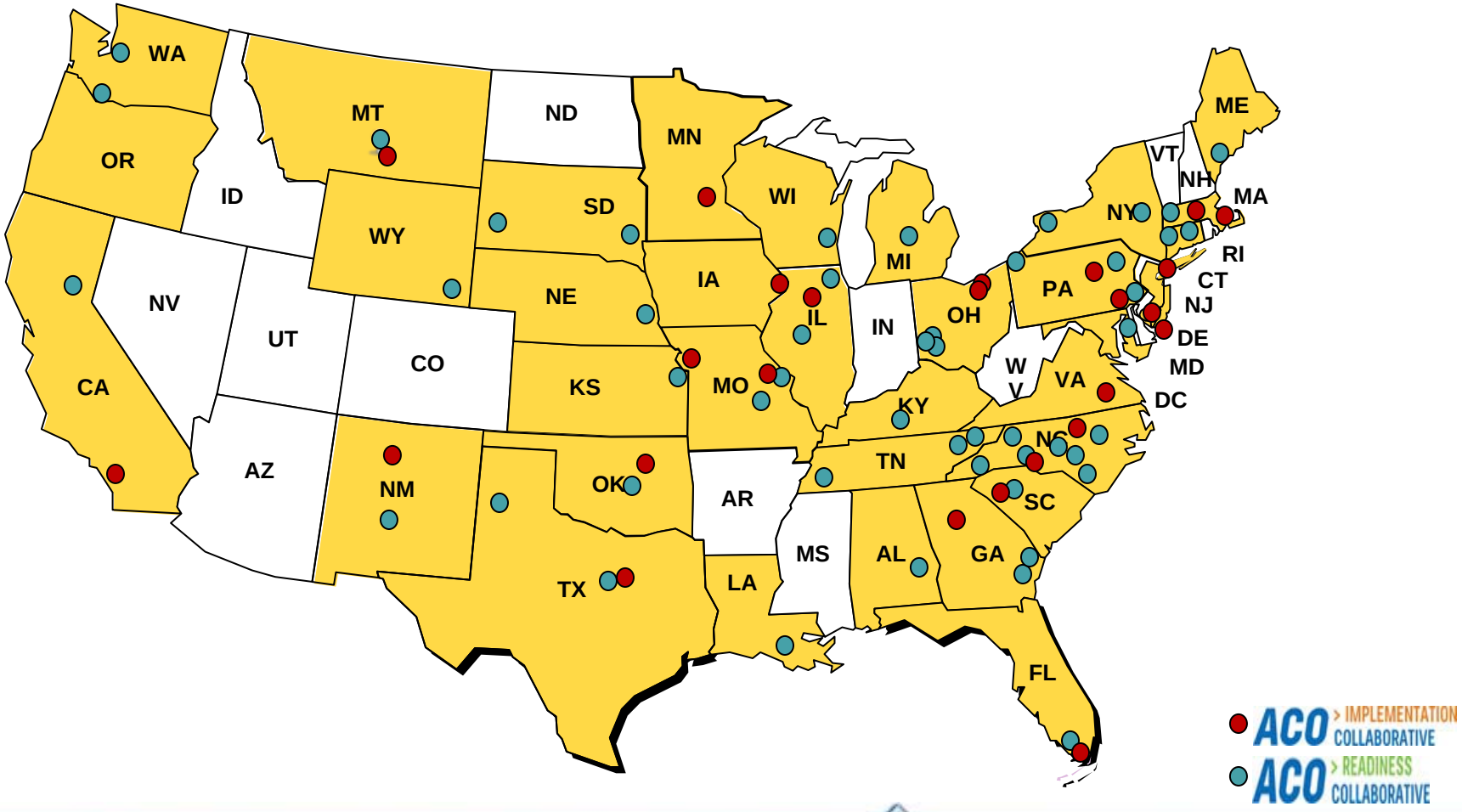
- Cart, then horse? Horse, then cart? OK, horse first!
- Wait! We don't have a cart yet!
- Now that we have a cart, let's really load it up!
- Remind me --why are we using horses?

….And legal barriers must be overcome

- In initial contracting, CMS should:
  - Give preference to ACOs already working with providers who can share data, initiate quality improvement and demonstrate patient-centeredness
  - Recognize many different ACO structural models
  - Recognize PAs, nurse practitioners, etc as eligible for bonuses
  - Educate the public, and notify them when they have been assigned to ACOs
  - Allow ACOs to contact people to increase engagement and improve care
  - Allow more than one ACO in an area
  - Leverage existing measures and transparently disclose them from the outset
  - Commit to share data across Parts A, B and D with ACOs in a timely manner
  - Allow multiple payment models (FFS +bonus, global payment, capitation,etc.)
  - Provide a safe harbor from anti-trust, Stark and CMP laws for all CMS ACOs

ACO Collaborative members

As of 09/02/2010



ACO Implementation Collaborative members

- Aria Health – Philadelphia, PA
- AtlantiCare – Atlantic City, NJ
- Baystate Health – Springfield, MA
- Billings Clinic – Billings, MT
- Bon Secours Health System, Inc. – Marriottsville, MD
  - Richmond, VA Market
  - Greenville, SC Market
- CaroMont Health – Gastonia, NC
- Fairview Health Services – Minneapolis, MN
- Geisinger Health System – Danville, PA
- Genesis Health System – Davenport, IA
- Hackensack University Medical Center – Hackensack, NJ
- Heartland Health – Saint Joseph, MO
- Hoag Memorial Hospital Presbyterian/ Greater Newport Physicians– Newport Beach, CA
- Methodist Medical Center – Peoria, IL
- Memorial Healthcare System – South Broward, FL
- North Shore - Long Island Jewish Health System – Great Neck, NY
- Presbyterian Healthcare Services – Albuquerque, NM
- Saint Francis Health System – Tulsa, OK
- Southcoast Hospitals Group – Fall River, MA
- SSM Health Care Corporation – St. Louis, MO
- Summa Health System – Akron, OH
- Texas Health Resources – Dallas, TX
- University Hospitals – Cleveland, OH
- WellStar Health System – Atlanta, GA

Diversity of participants, diversity of learning

- More than 1.4 million people will be covered in these local ACOs
- A presence in 33 states
- Cover urban, rural and suburban populations
- Communities from Winnsboro, TX, to Long Island, NY, ranging in size from 4,000 to 7.5 million residents
- Diverse group of payers, including owned health plans, non-profits, for-profits, employers and unions
- More than 80 hospitals

A variety of models being examined

- Payer partners: Employer, self-insured or commercial
- Beneficiaries: Hospital employees, chronic patients or all beneficiaries in a commercial plan
- ACO sizes: Small scale (5,000+ covered lives) up to hundreds of thousands of people
- ACO leadership structures: Hospital led with employed physicians, physician-led ventures or multi-provider networks.

We think it's important to test all these approaches to see the benefits of all, which could help providers in other communities decide which approach to pursue.

ACO models vary by community

AtlantiCare

- Launching by April 2011
- 88,000 covered lives
- Three Trump casinos, AtlantiCare employees and local Blue plan will participate
- Plan to expand to Medicare population by 2012

Hoag

- Launching by Jan 2012
- 13,500 covered lives
- Partnering with Greater Newport physicians
- Plan to apply for CMS contract for Medicare population
- Medicare Advantage population will participate

Fairview

- Want 50% of total revenues from shared savings
- Clinic model
- 600,000 covered lives
- Commercial and all major payers participating

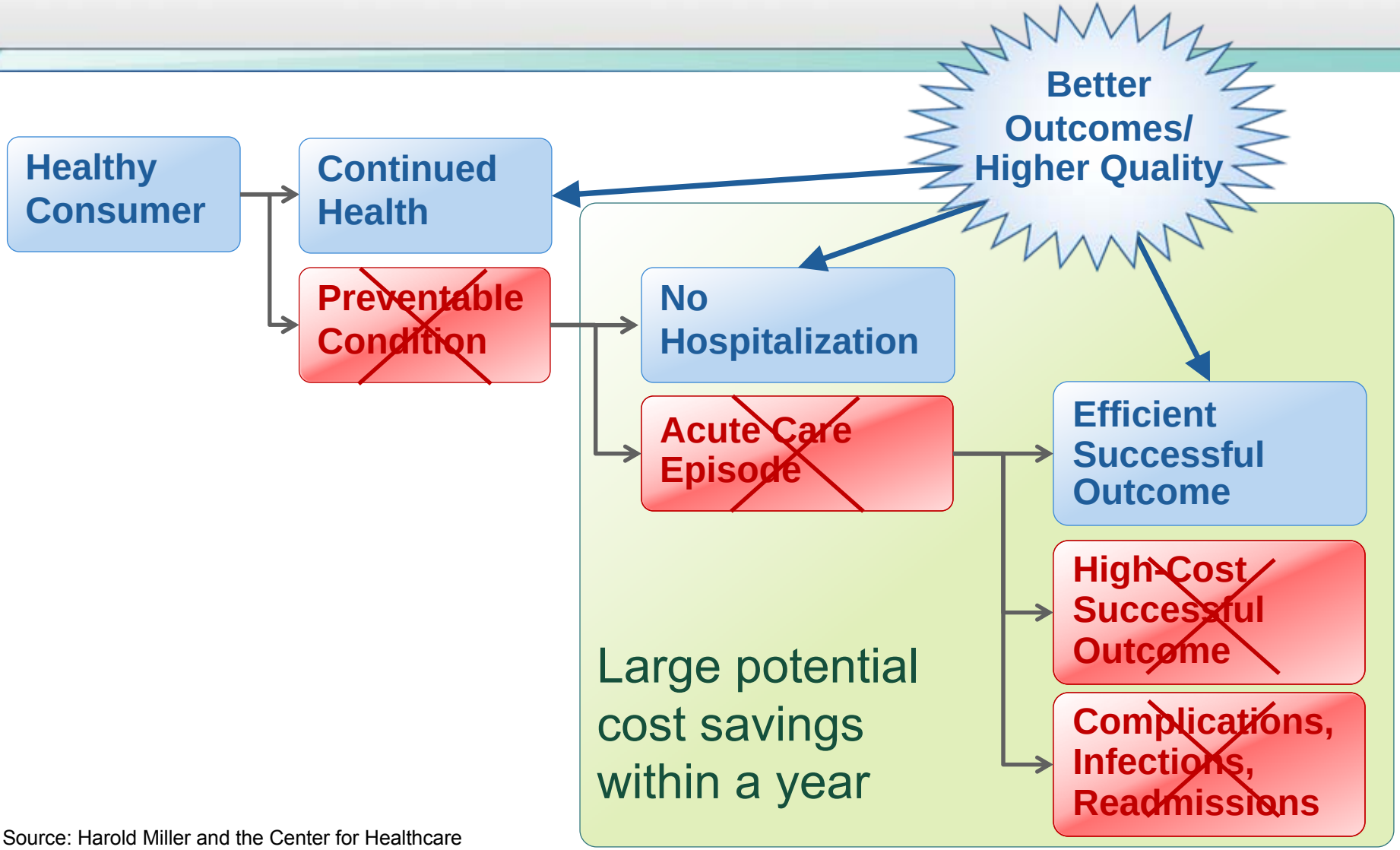
The challenge: What are ACOs really going to do?

How does that happen?
- They are going to ration care
- They will require cookbook medicine
- I'll spend more time reporting than practicing medicine
- I'll lose my autonomy
- I'll lose income
- They will consolidate market power for higher payment

How does that happen?
- Reduce costs by preventing illness and avoiding expensive care/ mistakes
- Engage physicians as leaders in ACO design
- Provide predictable pay and opportunities to earn new bonus income
- Move paperwork away from physicians to case managers, nurses, etc.
- Allow people to access care in less expensive, more convenient ways (at home, online, over the phone)
- Put people and providers, not insurers, in the driver's seat
- Rewarded with payment only if cost, satisfaction and quality goals are all met

Source: Harold Miller and the Center for Healthcare Quality and Payment Reform

What are we trying to incent?



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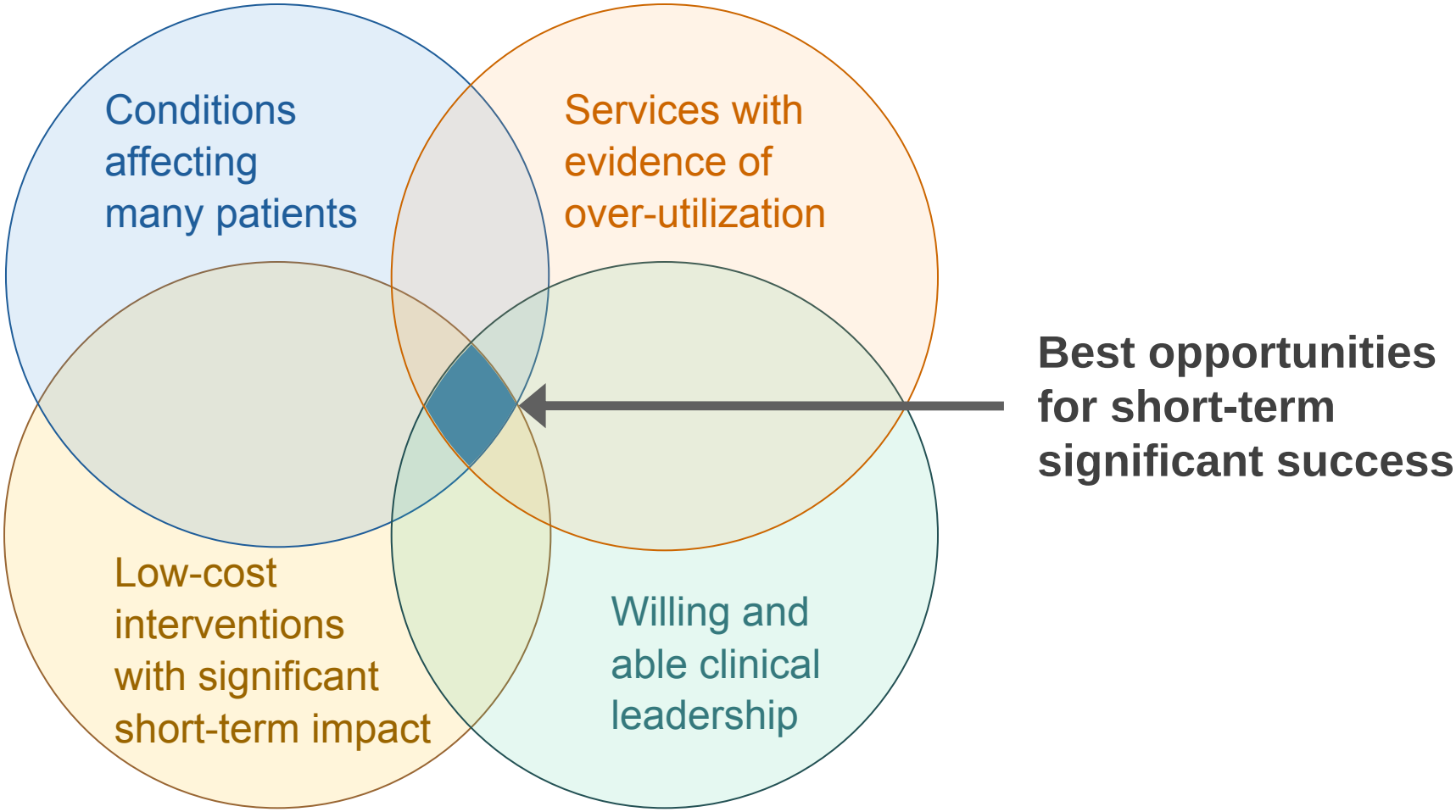
The ACO sweet spot



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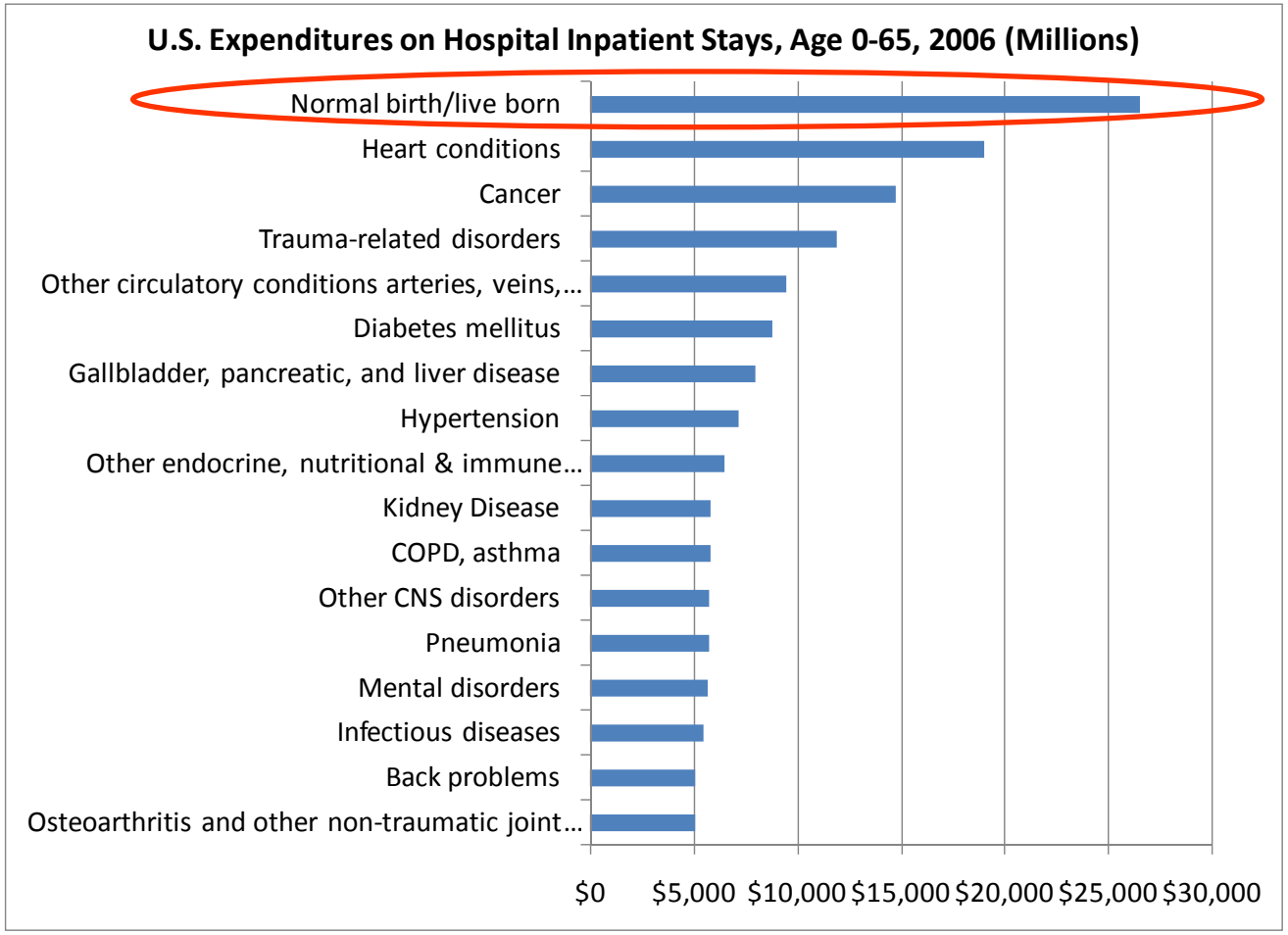
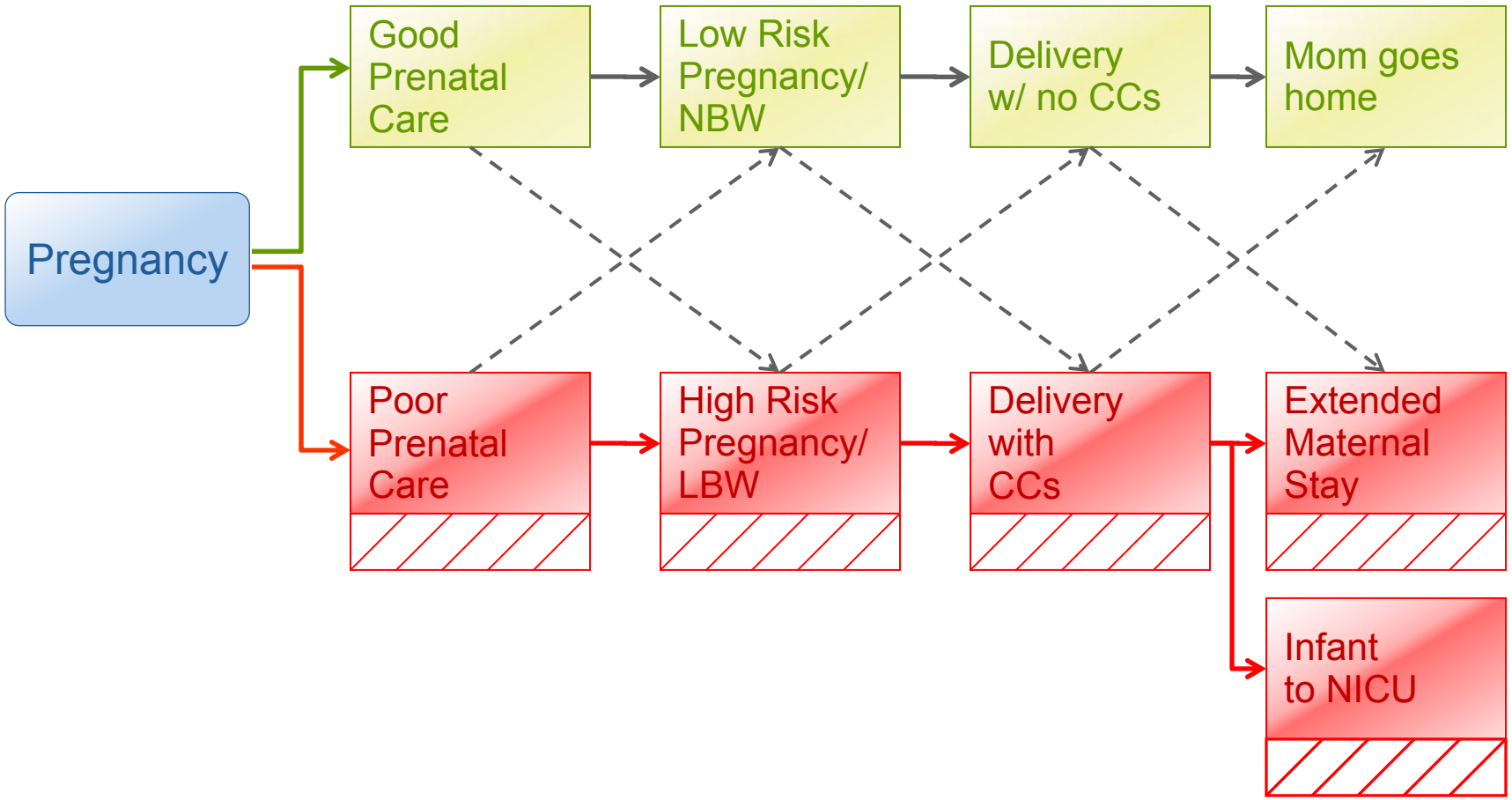
Show me the money: Maternity care is #1 hospital expenditure



Medical Expenditure Panel Survey, 2006

Many ways to enhance value in maternity care

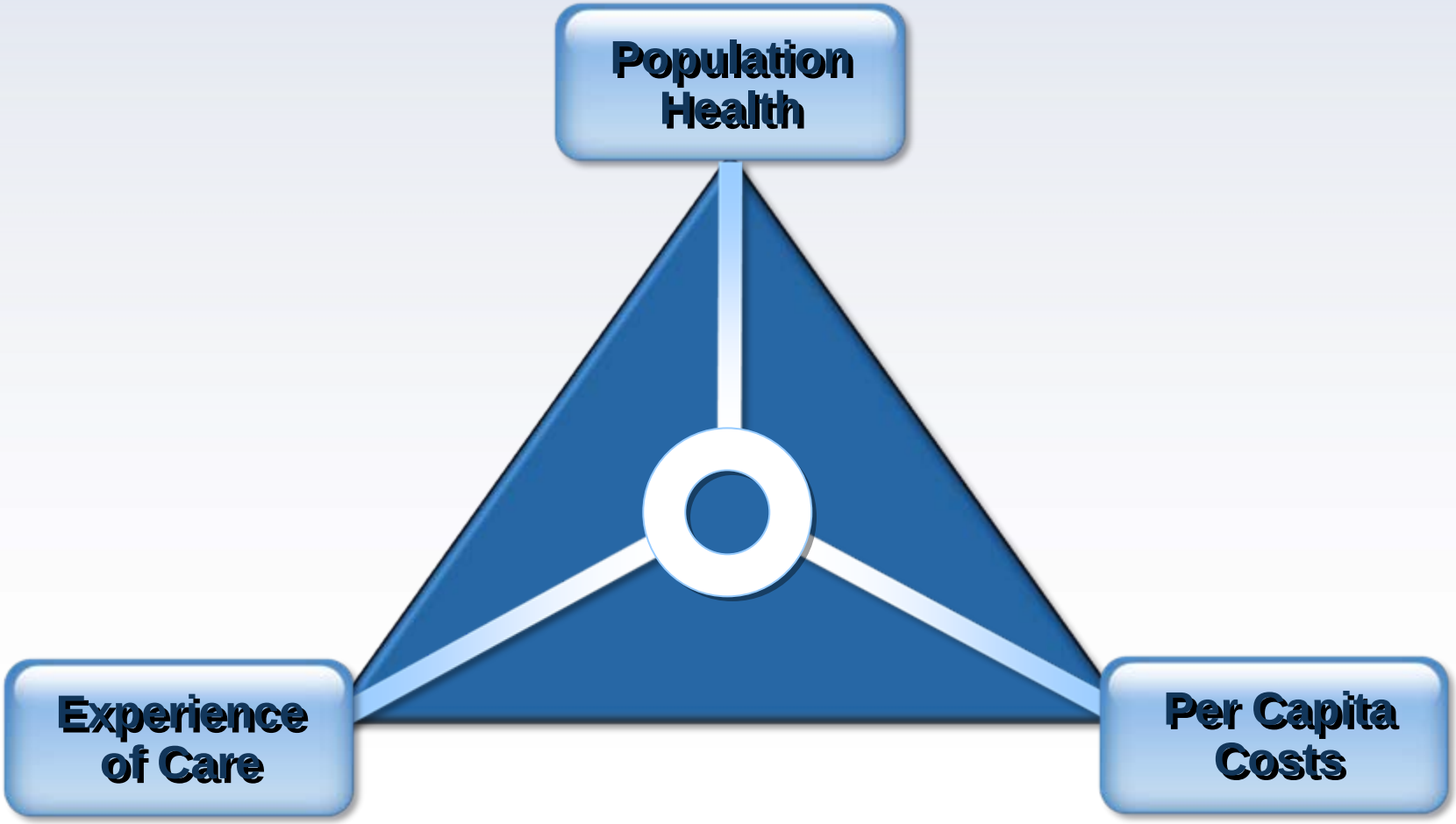


Source: Harold Miller and the Center for Healthcare Quality and Payment Reform

Perinatal Safety Initiative

- Reduced birth trauma (injuries to infants) by 11.6 percent against the baseline period.
- Reduced birth hypoxia and asphyxia, conditions that often cause infant brain damage, by 31.4 percent against the baseline period.
- Reduced the Adverse Outcome Index (AOI), by 6.4 percent against the baseline period.
- Identified $1.3 million in potential savings at 11 of the hospitals, an average of nearly $41 per delivery

Definition of reform's success:
Improving Triple Aim™ population outcomes



The term Triple Aim is a trademark of the Institute for Healthcare Improvement

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Movement Towards True Measures of Accountability

- Measurably improve the health of the population
  - Current: Measuring experience and quality of care as well as primary / secondary indicators of prevention of disease
  - Future: **Truly measure the health of the population: not how good we are at prevention – but rather how healthy the population actually is**
- Enhance the experience of care
  - Current: Measuring patient's satisfaction with their health care encounter
  - Future: **Measure how engaged and empowered people are within the health care system**
- Reduce total cost
  - Current: Measuring absolute cost
  - Future: **Measure risk adjusted efficiency of care to articulate difference between care expected versus care actually deployed**

Complete view of an operational ACO