Critical Elements of an ACO and How to Ensure Positive ROI

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Our background explains our passion...

- Began in 1997 as part of CareGroup managing 450,000 full risk capitated lives:
  - Developed fully integrated suite of tools to manage our medical expense and improve the quality of care
  - Integrated multiple third party engines to assure best of breed expert systems
  - Came to focus on communication and engagement capabilities as key to driving change
  - Spun out technology in 2005 as MedVentive

- Recognized for breakthroughs in cost & quality:
  - Microsoft HUG Award for Interoperability
  - U.S. Dept. of HHS
  - AIM Award
Our clients are in the game today

<table>
<thead>
<tr>
<th>ACO</th>
<th>Clinical Integration</th>
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<tbody>
<tr>
<td>Mount Auburn CAMDEN Physician Hospital Organization</td>
<td>Clarian Health</td>
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<tr>
<td>Centmass Association of Physicians</td>
<td>Vista Health System LLC</td>
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<tr>
<td>Lowell General Physician Hospital Organization</td>
<td>Hartford Physician Hospital Organization</td>
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<tr>
<td>Beth Israel Deaconess Physician Organization, LLC</td>
<td>Southern California Physicians Managed Care Services</td>
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With the backdrop of health reform, change is inevitable in the form of reimbursement and new care delivery models.

- Financial risk will shift from health plans to providers for managing populations of patients on a cost and quality basis.
Change is a good thing

Standing still is a risk too
Opting out of risk is not a good option

Non-risk FFS contracts result in:
• Deeply discounted fee schedules
• External controls for resource mgmt
• Case/referral management
• RBMs
• Specialty carve-outs with limited provider networks

Risk Contracts allow for:
• Provider-centric care management
• Surplus potential
Change has many faces

Don’t limit your thinking of risk as an all or none phenomenon.
- Where on this spectrum will you do best?
- Is a hybrid deal an option? Can you get more money by taking “some” risk? Risk with protection?
- Assess each payer carefully for the right deal
Change requires investment

- Leadership support and shared expectations
- Define effective organizational structure
- Payer contracting expertise
- Physician compensation incentives
- Population-based medical management
- Ability to turn data into insights and actions into results
Tactical to Practical

Practical approach to ensure success and an ROI
ROI starts with internal efficiency

- Address barriers: legal, heterogeneous performance, desire for autonomy, politics & governance
- Consolidate / standardize infrastructure and governance in a phased approach:
  - Reduce duplicate committees and boards
  - Consolidate credentialing, contracts/payments, audits
  - Realize infrastructure efficiencies of scale
    - Move to no Executive Directors -> maintain local Medical Directors
  - Fewer meetings and physician time
- Invest in shared IT infrastructure
  - Merge support functions – data management
ROI starts with smart contracting

- **Shared risk, not inflicted risk:**
  - Surplus potential with reasonable utilization goals
  - % of premium model, with severity adjustment
  - Segregating/minimizing uncontrollable risk

- **Funding by payers for MSO functions (33-100% of MSO budget)**

- **Ability to accept and manage delegated functions:**
  - Medical management, case management, referral management, and precertification
  - Credentialing

- **Foster active collaboration with the plans**
  - **Data, data, data**
  - Timely and frequent settlements to MSO & payments to providers
Technology is a key ROI driver

You need to transform data into powerful, clinically-valid, patient-specific interventions, with workflows that *accomplish real change in the field*. 
Increased risk requires more complex analytic tools

- **P4P**
- **Episode or disease based Bundled payment**
- **Full population capitation**

Clinical Integration Workflows

- Quality profiles
- Quality outreach
- Physician profiling
- Patient Engagement
- Case management
- Referral management
- Claims payment
- Panel efficiency profiling
- Physician reimbursement tool
- Member risk stratification

## Physician Performance Profiling

### Target Areas

<table>
<thead>
<tr>
<th>PCP Efficiency Profile Graphs</th>
<th>PCP Efficiency Profile Detail Reports</th>
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<tr>
<td>Specialist Efficiency Profiles</td>
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<tr>
<td>Quality Registries &amp; Profiles</td>
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<td>Patient Risk Stratification</td>
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<td>Leakage</td>
<td>Inpatient Usage</td>
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<tr>
<td>Emergency Room Detail</td>
<td>Emergency Room Frequent Flyers</td>
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<tr>
<td>Outpatient Imaging</td>
<td>Outpatient Visits</td>
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<tr>
<td>Drug Profile - PCPs</td>
<td>Drug Profile - Specialists</td>
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### Example Graphs

- **PCP Drug Utilization Profile**
  - [Graph showing drug utilization profile over time.]

- **Patient Risk Stratification**
  - [Graph indicating risk levels by patient.]

- **Emergency Room Frequent Flyers**
  - [Graph showing frequency of visits by PCP.]

- **Patient Risk Stratification**
  - [Graph showing risk levels by specialist.]
Address the confidence killers

“My patients are sicker”
“I had an outlier patient who was in the hospital for 6 months”
“This is not my patient”
“This patient shouldn’t be in this registry”
“This guideline isn’t applicable to this patient”

- Sophisticated methodology
- Physician feedback loops
- Supplemental data
Create tactical-practical action plans

- You can’t boil the ocean
- Use your analytics to identify 5-10 areas of targeted improvement, with a mix of quality & financial goals
- Invest in central staff: data, quality, case mgt, pharmacy
- Gain physician confidence:
  - Secure your clinical champions
  - Start publishing & explaining data long before you tie $$ to it -> need buy-in to measurements
- Have clear incentive plans
Success depends on three things…

- **Behavior change**
  - No “good” or “bad” physicians
  - Identify opportunities for improvement
  - Never punitive
  - The key is education

- **Reduce variation**
  - Reduce resource consumption
  - Manage leakage
  - Manage costs
  - Increase efficiency

- **Improve quality**
  - Identify actionable opportunities

- **Credible methodology and transparency**
  - No buy-in = no success
  - No credibility = DOA

- **Robust analytics to identify opportunities for improvement**
  - Sufficient detail to be actionable

- **Beyond reports**
  - Tools to outreach to physicians and patients
Success Stories
Case study: PHO

Environment:
• 2 hospital system; IPA with 315 physicians and 115 practices
• 50,000 patients
• Risk contracts with 4 major payers
• Robust technology environment (GE Centricity & Meditech)
• Clinical team: case management, pharmacist & quality manager

Needed:
• Enterprise oversight and reporting
• Creation of population management and all-payer registries
• Integration of lab, EMR and pharmacy data
• Decentralized system to engage physicians and care coordinators... create distributed disease management
• Cubes and data mart for power financial analytics
Quality improvement results

Quality results above the 90th percentile nationally for Diabetic care, adult & pediatric preventive care, women’s health and cardiovascular disease

<table>
<thead>
<tr>
<th>MEASURES</th>
<th>PHO</th>
<th>HEDIS National 90th percentile</th>
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<tbody>
<tr>
<td>HbA1c Screening</td>
<td>94.6%</td>
<td>93.2%</td>
</tr>
<tr>
<td>Eye Exam</td>
<td>84.0%</td>
<td>72.0%</td>
</tr>
<tr>
<td>LDL C Screening</td>
<td>92.1%</td>
<td>88.8%</td>
</tr>
<tr>
<td>Medical Attention for Nephropathy</td>
<td>88.9%</td>
<td>87.8%</td>
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Financial results

- Pharmacy:
  - Generic utilization above 75%
  - Saved $2M in pharmacy across total population

- Other highlights:
  - Frequent flyer report to manage ED costs
  - Leakage reports to analyze referrals to tertiary centers
    - Physician & patient engagement
  - Thousands of manually-entered supplemental data points each year
## Case study: Quality

- Large MA system
- High baseline performance
- Compared quality metrics managed w/ and w/o quality alerts
- Up to 10,000 eligible patients/metric
- 15,127 interventions
- Significant tier improvement over two years in publicly reported scores

<table>
<thead>
<tr>
<th></th>
<th>QIM Intervention Group</th>
<th>No Intervention Group</th>
<th>Improvement with QIM (%)</th>
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<tbody>
<tr>
<td><strong>Metrics Improved</strong></td>
<td>92 %</td>
<td>72 %</td>
<td></td>
</tr>
<tr>
<td><strong>Mean Absolute Compliance Rate Improvement</strong></td>
<td>4.6 %</td>
<td>1.7 %</td>
<td>334 %</td>
</tr>
<tr>
<td><strong>Percent of Non-Compliant Patients that Became Compliant</strong></td>
<td>24 %</td>
<td>6%</td>
<td>277 %</td>
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</tbody>
</table>
Case study: Reducing Rx expense

Commercial Population

% Generic Utilization

Medicare Population

% Generic Utilization

Significant improvement even among high performing organizations
Case studies: Pharmacy

- **Client A:**
  - Over 1,000 pharmacy interchanges for the first 6 months of 2009, with over $412,000 savings realized

- **Client B:**
  - Over 1,350 interchanges for $642,000 in savings.

- **Client C:**
  - Over 2,000 interchanges for $953,273 in savings.

- **Client D:**
  - Over 10,000 exclusions in the system

Pharmacy interchanges to patients and physicians
Universal value drivers*

- Increase Operational Capacity: 17%
- Control Pharmacy Costs: 10%
- Reduce Utilization: 32%
- Optimize Quality Performance: 41%

* Research conducted by Hobson & Company
Universal value drivers: The detail

#1: Increase Operational Capacity

<table>
<thead>
<tr>
<th>Value Drivers</th>
<th>Type *</th>
<th>Specific Benefit (#)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase Operational Capacity</td>
<td>P</td>
<td>1. Increase capacity to reach members with actionable interventions</td>
</tr>
<tr>
<td></td>
<td>P</td>
<td>2. Improve the efficiency of physician educational outreach efforts</td>
</tr>
<tr>
<td></td>
<td>P</td>
<td>3. Enable providers to perform more population management at the practice level</td>
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* C = Cost savings, P = Productivity Gain, R = Revenue Gain
Universal value drivers: The detail

#2: Optimize Quality Performance

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<th>Specific Benefit (#)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Optimize Quality Performance</td>
<td>C</td>
<td>4. Better manage chronic disease populations to optimize quality and cost of care</td>
</tr>
<tr>
<td></td>
<td>R</td>
<td>5. Protect member retention through consistent public quality reporting</td>
</tr>
<tr>
<td></td>
<td>R</td>
<td>6. Improve ability to hit incentive targets</td>
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#3: Reduce Utilization

<table>
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<th>Specific Benefit (#)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce Utilization</td>
<td>R</td>
<td>7. Contain medical expenses via physician efficiency profiling and outreach</td>
</tr>
<tr>
<td></td>
<td>C</td>
<td>8. Better manage ER utilization</td>
</tr>
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Universal value drivers:
The detail

#4: Control Pharmacy Costs

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<th>Type *</th>
<th>Specific Benefit (#)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control Pharmacy Costs</td>
<td>C</td>
<td>9. Maximize generic utilization through member specific drug interventions</td>
</tr>
<tr>
<td></td>
<td>C</td>
<td>10. Contain drug costs through physician profiling, education and formulary compliance</td>
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Anticipated ROI

- 3X ROI, 7 benefits
- Good breadth and distribution

Top benefits (Annual Value):
- Maximize generic utilization through patient specific drug interventions = $1.7M
- Contain medical expenses through physician efficiency profiling and outreach = $1.0M
- Better manage chronic disease populations to optimize quality and cost of care = $750K
- Protect patient retention through consistent public quality reporting = $680K
- Protect ability to hit incentive targets = $500K

Payback period: 10.5 months
3 Year ROI: 276%
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