CONCURRENT SESSION XIX: Are You Ready for Accountable Care and How to Make it Work?!
Bringing Value to Healthcare Delivery: Moving From *Volume*-driven Healthcare to *Value*-driven Healthcare

**Agenda**

**The Quiz**

Healthcare Evolution

Value Based Care Delivery

Case Studies

Making it Work - Charting Your Future
1. Out of 35 “G-7” countries, the USA is ranked (#) ______ in Health Status.

A. Top 5  
B. Top 10  
C. Top 20  
D. 29+
2. ____ percent of the USA’s total GNP ($16 trillion) is for healthcare expenditures:
   A. <5 %
   B. 11 %
   C. 17 %
   D. 23 %
3. _____ percent of the people create 50 percent of the costs.

A. 5%    B. 12%    C. 20%    D. 28%
Baseline Questions

4. What percent of the time do patients receive treatment at the “Standard of Care?”

A. 75 % +
B. 65 %
C. 55 %
D. 45 %
5. 135 physicians queried; same patient information. How many different diagnoses/treatment paths were given?

(#) _______________
Believe It…or Not!

1. (D) The USA is ranked 29th out of 35 G-7 countries in terms of Health Status.
2. (C) 17.6% of the total U.S. Gross National Product ($16 trillion) is for healthcare expenditures. ($2 trillion; $7,000 per person)
3. (A) Five percent of the people in the USA create 50% of the costs.
4. (C) 55% of the time patients receive the “Standard of Care” treatment. (Source: Rand Corporation Study)
5. 82 different diagnoses; 135 physicians queried, same patient information. (Source: “Strong Medicine”)

Key to Questions
Agenda

The Quiz
Healthcare Evolution/Revolution
Value Based Care Delivery
Case Studies
Making it Work - Charting Your Future

Average spending on health per capita ($US PPP*)

- United States
- Germany
- Canada
- France
- Australia
- United Kingdom

Total expenditures on health as percent of GDP

* PPP=Purchasing Power Parity.

Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2008
Total National Health Expenditures, 2008–2017  Projected and Various Scenarios

Dollars in Trillions

- Projected under current system
- Building Blocks plus selected individual options*
- Spending at current proportion (16.2%) of GDP

* Selected individual options include improved information, payment reform, and public health.

# Core Themes of Healthcare Reform

## Proposed Method

<table>
<thead>
<tr>
<th><strong>Expand Coverage</strong></th>
<th><strong>Paying for It</strong></th>
<th><strong>Payment Reform</strong></th>
<th><strong>Delivery System Reform</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Expand Medicaid</td>
<td>Increase payroll taxes on high earners</td>
<td>Reduced payment for hospitals with high readmission rates</td>
<td>Medicare Bundling pilots</td>
</tr>
<tr>
<td>Subsidies for moderate income individuals</td>
<td>Tax on “Cadillac” plans</td>
<td>Value-based purchasing (“VBP”) program - hospitals and physicians</td>
<td>Accountable Care Organizations (“ACO”)</td>
</tr>
<tr>
<td>No exclusions for pre-existing conditions</td>
<td>Disproportionate Share Hospital (“DSH”) payments reduced</td>
<td>Further payment reductions for healthcare - acquired conditions</td>
<td>CMS Center for Medicare and Medicaid Innovation (“CMI”)</td>
</tr>
<tr>
<td>Create new market competition for health insurance</td>
<td>Drug companies, medical device, and health insurers assessed fees</td>
<td>Increased payments for primary care services - more for shortage areas</td>
<td>Medicaid payment demonstration projects</td>
</tr>
<tr>
<td>Individual and employer mandates</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The Camden Group
PPACA and CI/Accountable Care – Timing and Key Provisions

- **2010**
  - Tax Credits to Small Employers
  - Medicaid Global Payment System Demonstration

- **2011**
  - Fees on Drug Makers
  - Begin reductions in annual updates to FFS Medicare rates

- **2012**
  - Voluntary ACOs

- **2013**
  - Create Co-Ops
  - Tax High-income earners
  - Tax investment income
  - Tax medical devices

- **2014**
  - Exchanges created
  - Mandated insurance coverage
  - Insurance industry fees
  - Reductions in DSH payments

- **2015**
  - Reduced payment for hospital acquired conditions
  - Insurance industry fees
  - Reductions in DSH payments

- **2016**
  - Increased penalty for individuals without insurance
  - Permits states to form healthcare choice compacts

- **2018**
  - Tax on “Cadillac Plans”

Billions

Additional Uninsured Covered

- Spending Cuts and New Taxes/Fees
- Expanded Coverage and Tax Credits
- Additional Insured Individuals
## Mixed Bag (Win and Lose) in Healthcare Reform

<table>
<thead>
<tr>
<th>Hospitals</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Win</strong></td>
<td></td>
</tr>
<tr>
<td>- Reduced bad debt</td>
<td></td>
</tr>
<tr>
<td>- More insured users</td>
<td></td>
</tr>
<tr>
<td>- No more new physician-owned hospitals as of January 1, 2011</td>
<td></td>
</tr>
<tr>
<td><strong>Lose</strong></td>
<td></td>
</tr>
<tr>
<td>- Decrease to federal aid dollars distributed as Disproportionate Share Hospital (DSH) to those hospitals that receive it</td>
<td></td>
</tr>
<tr>
<td>- No relief for uninsured undocumented aliens who must be cared for under EMTALA</td>
<td></td>
</tr>
<tr>
<td>- Medicare payment update reductions - estimated to be $14.8 billion over ten years</td>
<td></td>
</tr>
<tr>
<td>- Less ability to cost shift</td>
<td></td>
</tr>
<tr>
<td>- Payer mix will shift as baby boomers move into Medicare and revenue per unit decreases</td>
<td></td>
</tr>
<tr>
<td>- Overall pressure to decrease costs increase as cost of programs becomes apparent</td>
<td></td>
</tr>
<tr>
<td>- New payment models (e.g., Accountable Care Organization (“ACO”), bundled payments) will work to decrease inpatient utilization and margin loss.</td>
<td></td>
</tr>
</tbody>
</table>
### Mixed Bag (Win and Lose) in Healthcare Reform (cont’d)

<table>
<thead>
<tr>
<th>Physicians</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Win</strong></td>
<td>More insured patients for those with poor payer mix – reimbursement enhanced for those with high uninsured</td>
</tr>
<tr>
<td></td>
<td>Enhanced reimbursement for community clinics</td>
</tr>
<tr>
<td></td>
<td>Ability to access shared savings (increase beyond FFS) from bundled payment/ACOs</td>
</tr>
<tr>
<td></td>
<td>PCPs will have an increase in pay from Medicaid (2013/14) and Medicare (rural, HPSA)</td>
</tr>
<tr>
<td><strong>Lose</strong></td>
<td>Add to patient load of physicians which could create access issues and exacerbate physician shortage</td>
</tr>
<tr>
<td></td>
<td>No resolution to the SGR – sustainable growth rate calculation</td>
</tr>
<tr>
<td></td>
<td>Independent physicians with no access to clinical reporting tools will find it more difficult to compete</td>
</tr>
<tr>
<td></td>
<td>No tort relief</td>
</tr>
</tbody>
</table>
Healthcare Reform: What was the Debate?

**Health Plans (Choice)**
- Flexible
- Varies
- 4-5%
- Negotiated

**American Health Benefits Exchange**
- 4 Options
- Established
- None
- Negotiated

- Benefits
- Premium
- Profit Margin
- Provider Payment
Health Connector Connects Individuals and Families to Health Insurance in the State of Massachusetts

The Health Connector offers plans from:

Exemptions from the Mandate
Think you can’t afford health insurance? Learn if you might be exempt from the Health Care Reform law’s penalties.
More on exemptions

Did Your Employer Send You?
Use your Employer ID to shop for a plan. Get tax-free savings on health insurance.
Go to the “Employees” area

Time to Renew?
Commonwealth Choice members must call 1-866-636-4654 to change plans. The TTY line for hearing or speech-impaired callers is 1-888-213-8163. Please act in time to stay covered.

Self Employed?
Use “total business income” as reported on your federal taxes if you’re trying to qualify for a low-or-no-cost Commonwealth Care plan.
Contact us

Important Dates
For coverage on: Apply & pay by:
Oct. 1, 2010 Sept. 23, 2010
Nov. 1, 2010 Oct. 22, 2010

Quick Links
Frequently asked questions

Real Customers
Ada May and Donald Roberts of
Choose the type of plans that will meet your needs.

**Bronze**
- Lower monthly cost
- Higher costs when you receive medical services

Who chooses Bronze plans?
See Bronze Plans

**Silver**
- Monthly cost can run higher than Bronze
- Lower costs when you receive medical services compared to Bronze

Who chooses Silver plans?
See Silver Plans

**Gold**
- Highest monthly cost
- Lowest costs when you receive medical services

Who chooses Gold plans?
See Gold Plans

OR

View all plans
Benefits versus Price…Finding the Right Fit

Show Plans. Then choose up to 3 to compare. Click **Continue** at bottom.

<table>
<thead>
<tr>
<th>Plan</th>
<th>Monthly Cost</th>
<th>Annual Deductible</th>
<th>Annual Out of Pocket Max.</th>
<th>Doctor Visit</th>
<th>Generic Rx</th>
<th>Emergency Room</th>
<th>Hospital Stay</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bronze Low Benefits Package</strong></td>
<td>as low as $676</td>
<td>$2,000 (ind.) $4,000 (fam.)</td>
<td>$5,000 (ind.) $10,000 (fam.)</td>
<td>annual deductible, then $25 copay</td>
<td>annual deductible, then $15 copay</td>
<td>annual deductible, then $100 copay</td>
<td>annual deductible, then 20% co-insurance</td>
</tr>
<tr>
<td><strong>Bronze Medium Benefits Package</strong></td>
<td>as low as $736</td>
<td>$2,000 (ind.) $4,000 (fam.)</td>
<td>$5,000 (ind.) $10,000 (fam.)</td>
<td>$30 copay</td>
<td>$10 copay</td>
<td>annual deductible, then $150 copay</td>
<td>annual deductible, then $500 copay</td>
</tr>
<tr>
<td><strong>Bronze High Benefits Package</strong></td>
<td>as low as $707</td>
<td>$250 (ind.) $500 (fam.)</td>
<td>$5,000 (ind.) $10,000 (fam.)</td>
<td>$25 copay</td>
<td>$15 copay</td>
<td>$150 copay</td>
<td>annual deductible, then 35% co-insurance</td>
</tr>
<tr>
<td><strong>Silver Low Benefits Package</strong></td>
<td>as low as $955</td>
<td>$1,000 (ind.) $2,000 (fam.)</td>
<td>$2,000 (ind.) $4,000 (fam.)</td>
<td>$20 copay</td>
<td>$15 copay</td>
<td>annual deductible, then $100 copay</td>
<td>annual deductible, then no copay</td>
</tr>
<tr>
<td><strong>Silver Medium Benefits Package</strong></td>
<td>as low as $1,009</td>
<td>$500 (ind.) $1,000 (fam.)</td>
<td>$2,000 (ind.) $4,000 (fam.)</td>
<td>$20 copay</td>
<td>$15 copay</td>
<td>$100 copay</td>
<td></td>
</tr>
<tr>
<td><strong>Silver High Benefits Package</strong></td>
<td>as low as $961</td>
<td>None</td>
<td>None</td>
<td>$25 copay</td>
<td>$15 copay</td>
<td>$100 copay</td>
<td>$500 copay</td>
</tr>
<tr>
<td><strong>Gold Benefits Package</strong></td>
<td>as low as $1,174</td>
<td>None</td>
<td>None</td>
<td>$20 copay</td>
<td>$15 copay</td>
<td>$75 copay</td>
<td>$150 copay</td>
</tr>
</tbody>
</table>
Payment Impact on Hospitals

Current Breakeven

Total Contribution Margin

$ |

Payer Type

Commercial | Medicare | Medicaid | Indigent/No Pay | Undocumented Aliens

DSH

THE CAMDEN GROUP
Payment Impact on Hospitals

How to achieve new breakeven level?
- Accountable Care Organization
- Clinical Integration
- Clinical Care Process Redesign
- Operations Improvement

Payer Type

- Commercial
- Medicare
- Medicaid
- Indigent/No Pay
- Undocumented Aliens

New Breakeven

New Users

Total Contribution Margin

$
Agenda

Quiz
Healthcare Evolution/Revolution
Value Based Care Delivery
Case Studies
Charting Your Future
New Delivery System Paradigm:

Increase the Defined Population We Care For

“Assigned” Defined Population

- Patient Responsibility
- Primary Care
- Medical Specialists
- Surgical Specialists
- Tertiary
- Quaternary

Likelihood of Inpatient Stay or Cost

High

Low
## Clinical Needs Have Changed

<table>
<thead>
<tr>
<th>Year</th>
<th>Life Expectancy</th>
<th>Leading Causes of Death</th>
<th>Clinical Need</th>
</tr>
</thead>
<tbody>
<tr>
<td>1900</td>
<td>47</td>
<td>Pneumonia, Influenza, Tuberculosis, Diarrhea, GI disease</td>
<td>Acute</td>
</tr>
<tr>
<td>1950</td>
<td>68</td>
<td>Heart Disease, Cancer, Cerebrovascular</td>
<td>Acute Chronic</td>
</tr>
<tr>
<td>2000</td>
<td>77</td>
<td>Heart Disease*, Cancer*, Cerebrovascular</td>
<td>Chronic Acute Prevention</td>
</tr>
</tbody>
</table>

* Cancer is currently the leading cause of death for certain age groups
Changing Patient Care Needs

Well
No Disease

At Risk
Smoke
Lack of Exercise

Acute Episodic Illness
Doctor Visits
Emergency Visits
Hospitalization

Chronic Illness
Diabetes
Coronary Heart Disease

Catastrophic
Head Injury
Cancer

20% members = 80% cost

80% members = 20% cost

Source: Mercer
Resource Availability May Drive Spending, but Other Factors Must be Considered


<table>
<thead>
<tr>
<th></th>
<th>Illinois</th>
<th>Indiana</th>
<th>Florida</th>
<th>Minnesota</th>
<th>United States</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Beds per 1,000 Residents</td>
<td>2.7</td>
<td>2.8</td>
<td>2.9</td>
<td>3.0</td>
<td>2.7</td>
</tr>
<tr>
<td>Registered Nurses per 1,000 Residents</td>
<td>9.0</td>
<td>9.0</td>
<td>8.0</td>
<td>10.7</td>
<td>8.4</td>
</tr>
<tr>
<td>Physicians per 1,000 Residents</td>
<td>3.3</td>
<td>2.6</td>
<td>3.2</td>
<td>3.4</td>
<td>3.2</td>
</tr>
<tr>
<td>Medicare Spending per Beneficiary (Adjusted for age, sex, and race)</td>
<td>$8,822</td>
<td>$7,931</td>
<td>$9,854</td>
<td>$6,974</td>
<td>$8,682</td>
</tr>
</tbody>
</table>

*Includes Grande Ronde Hospital, St. Elizabeth Health Services and Wallowa Memorial Hospital

Sources: Kaiser Family Foundation. (2010). Hospital Beds per 1,000 Population, 2008; Registered Nurses per 100,000 Population, 2008; Nonfederal Physicians per 1,000 Population, 2008. Link: http://statehealthfacts.org/comparecat.jsp?cat=8.
Link: http://www.dartmouthatlas.org/interactive_map.shtm.
Physician-Hospital Integration: Driving the Value Proposition

Impact on Value

- COE/ Specialty Institutes
- Specialty Co-management
- Managed Care Shared Risk
- Bundled Payments
- Clinical Integration
- Medical Foundation PSA
- Physician-owned Hospital
- ACO
- IDS

Integration

Limited  |  Full
Estimated Cumulative Percentage Changes in National Health Care Expenditures, 2010 through 2019, Given Implementation of Possible Approaches to Spending Reform


HIT denotes health information technology, NP nurse practitioner, and PA physician assistant.
Agenda

Quiz
Healthcare Evolution
Value Based Care Delivery
Case Studies
Charting Your Future
“Change is good; you go first.”
The Patient-centered Medical Home

<table>
<thead>
<tr>
<th>NCQA Accreditation Standards</th>
<th>Payment Models</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Access and communication</td>
<td>Enhanced FFS E&amp;M Payment</td>
</tr>
<tr>
<td>2. Patient tracking and registry functions</td>
<td>Additional FFS Codes for Medical Home</td>
</tr>
<tr>
<td>3. Care management</td>
<td>PMPM to Augment FFS</td>
</tr>
<tr>
<td>4. Patient self-management support</td>
<td>Risk-adjusted Comprehensive PMPM</td>
</tr>
<tr>
<td>5. Electronic prescribing</td>
<td></td>
</tr>
<tr>
<td>6. Test tracking</td>
<td></td>
</tr>
<tr>
<td>7. Referral tracking</td>
<td></td>
</tr>
<tr>
<td>8. Performance reporting and improvement</td>
<td></td>
</tr>
<tr>
<td>9. Advanced electronic communications</td>
<td></td>
</tr>
</tbody>
</table>
Co-management Aligns Interest Without Full Integration

- Management company governance is typically equally split between the Hospital and physician investors.
- Equity split does not need to be 50/50, but typically is. Goal is to create an attractive arrangement for both the physicians and the hospital. The equity arrangement determines the distribution on returns.
Organizational Structure: Sample PSA

- Health System
  - Medical Foundation 501(c) (3)
    - Support Services
      - Non-provider Staffing
      - Billing/Collections
      - Information Technology
      - Finance
      - Contracting
    - PSA
      - Research
      - Health Education
        - Community Medical
      - Physicians
        - Individual physicians
        - Medical Groups
        - Clinical
Medicare Solution: Bundled Payment – Acute Care Episode

- Demonstration project (1/1/09 – 12/31/11)
  - Baptist Health System (San Antonio, TX)
  - Hillcrest Medical Center (Tulsa, OK)
  - Oklahoma Heart Hospital (Oklahoma City, OK)
  - Exempla Saint Joseph Hospital (Denver, CO)
  - Lovelace Health System (Albuquerque, NM)

- Tie payment to performance outcome
- Target hospital admission plus 15 days
- Goal: Better coordinated care to create savings
- Each site selected: “Value-based Care Center”
  - CMS will market to Medicare beneficiaries
  - High volume procedures:
    - 28 cardiac; 9 Orthopedic

- Bundled payment (hospital and physician)
  - Includes Parts A and B during the inpatient stay

<table>
<thead>
<tr>
<th>Current</th>
<th>Demonstration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital receives DRG payment</td>
<td>One bundled payment based on outcome to a PHO</td>
</tr>
<tr>
<td>Physician receives Medicare</td>
<td></td>
</tr>
<tr>
<td>Physician Fee Schedule for each service</td>
<td></td>
</tr>
</tbody>
</table>

Conflicting Incentives?
Sample CMS Check

Medicare Acute Care Episode Demonstration
Shared Savings Payment
TFS Group, Inc.
P.O. Box 1001, McLean, VA 22102
ph: 877-402-3693

Name
Street Address
City, State ZIP

Dear ______:

Medicare is conducting a number of projects designed to improve the quality of health care for people with Medicare and reducing the costs of care. In one of our current projects, the Acute Care Episode Demonstration, some hospitals and their doctors are charging Medicare discounted fees for certain surgical procedures. Under this project, hospitals must provide detailed reports on the quality of care related to these surgical procedures. **To encourage people with Medicare to use these hospitals, Medicare is sharing up to half of its savings with patients who undergo one of these procedures.**

The attached check for $_______ represents your share of what Medicare saved on your recent stay at (hospital)_______, which ended on ____ (discharge date)_____. You are responsible for paying any Federal, state, and other taxes that may be owed on this amount. At the end of the calendar year, you will receive an IRS Form 1099 reflecting this amount as taxable income.

Please contact Medicare’s contractor, TFS Group, Inc., at 1-877-402-3693 if you have any questions regarding this check. If you have any questions regarding this project or your hospital stay, please contact _______ (hospital)________ at _______ (hospital’s demo Information number)__________.

Thank you for being a part of this important project.

Sincerely,

Cynthia Mason
Project Officer
Acute Care Episode Demonstration
Office of Research, Development, and Information
Bundled Payment: Financial Impact

Our Experience

- Increased one to two cardiac cases per day
- Decreased five to ten percent in actual costs per case
- Ten percent increase in efficiency
- Depending upon current cost/case, realized $3 to $6 million annually in total effect *

* Assumes MD payments equal fee revenue in flow
### Commercial Bundled Payments

<table>
<thead>
<tr>
<th>Target Date:</th>
<th>August 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Who:</strong></td>
<td><img src="images" alt="Logos" /></td>
</tr>
<tr>
<td><strong>Procedures:</strong></td>
<td>Selected Orthopedic (hip and knee replacement, etc.) procedures</td>
</tr>
</tbody>
</table>
What is an ACO?.... A Collection of Definitions...

- Establish a shared savings program that promotes accountability for a patient population and encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery, not later than January 1, 2012 (The Brookings Institute, 2009).

- Fostering clinical excellence and continual improvement while effectively managing costs by incentivizing hospitals, physicians, post-acute care facilities, and other providers involved to form linkages that facilitate coordination of care delivery throughout different settings, and collection and analysis of data on costs and outcomes (Nelson, 2009).

- The development of legal agreements between hospitals, primary care providers, specialists, and other providers to align the incentives of these providers to improve healthcare quality and slow the growth of healthcare costs by promoting more efficient use of treatments, care settings, and providers (Miller, 2009).

- The development of partnerships between hospitals and physicians to coordinate and deliver efficient care; and remove existing barriers to improving the value of care, including a payment system that rewards the volume and intensity of provided services instead of quality and cost performance and widely held assumptions that more medical care is equivalent to higher quality care (Fisher, 2006, 2009).

- Multiple providers assuming joint accountability for improving healthcare quality and slowing the growth of healthcare costs (PPACA, 2010).

- An organization of healthcare providers that agrees to be accountable for the quality, cost, and overall care of Medicare beneficiaries who are enrolled in the traditional fee-for-service program who are assigned to it (CMS).
Who Can Be An ACO?

- Group practices
- Networks of individual practices
- Partnerships or JV arrangements between hospitals and ACO professionals
- Hospitals employing ACO professionals
- Such other groups of providers of services and suppliers as the Secretary determines appropriate

ACO Professionals

- A doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such function or action, including osteopathic practitioners or the services of osteopathic practitioners and hospitals within the scope of their practice as defined by State law
- A physician assistant, nurse practitioner, or clinical nurse specialist
- A certified registered nurse anesthetist
- A certified nurse-midwife
- A clinical social worker
- A clinical psychologist
- A registered dietitian or nutrition professional

Source: CMS Medicare “Accountable Care Organizations” Shared Savings Program – New Section 1899 of Title XVIII; Social Security Act Sections 1861 and 1842
How Do You Qualify for the Medicare Program?

- Become accountable for the quality, cost, and overall care
- Minimum three-year period
- Have a formal legal structure to receive and distribute payments for shared savings
- Have enough PCPs
- Have a minimum of 5,000 beneficiaries
- Leadership and management structure that includes clinical and administrative systems
- Processes to promote evidence-based medicine and patient engagement, report on quality and cost measures, and coordinate care
- Meets patient-centeredness criteria
NCQA Guiding Principles for Draft ACO Criteria Development

ACOs…

1. Have a strong foundation of primary care.
2. Report reliable measures to support quality improvement and eliminate waste and inefficiencies to reduce cost.
3. Are committed to improving quality, improving patient experience, and reducing per capita costs.
4. Work cooperatively towards these goals with stakeholders in a community or region.
5. Create and support a sustainable workforce (e.g., primary care providers).

From NCQA’s Accountable Care Organizations (ACO) Draft 2011 Criteria Overview – released October 19, 2010 for public comment
Draft ACO criteria reflect the core capabilities accountable organizations must possess:

1. Program Structure Operations
2. Access and Availability
3. Primary Care
4. Care Management
5. Care Coordination and Transitions
6. Patient Rights and Responsibilities
7. Performance Reporting

From NCQA’s Accountable Care Organizations (ACO) Draft 2011 Criteria Overview – released October 19, 2010 for public comment
NCQA Draft ACO Scoring Levels

- Based on the organization’s demonstrated capability to function as an accountable entity and achieve 1) improved quality, 2) increased patient satisfaction, and 3) lower per capita costs.

1. **Established ACO Infrastructure and Processes that Promote Patient Care and Quality Improvement**
2. Integration of electronic clinical systems, integrate data for reporting/quality improvement
3. Report standardized, nationally accepted measures on clinical quality, patient satisfaction, and cost
4. Demonstration of Excellence or Improvement in Metrics

From NCQA’s Accountable Care Organizations (ACO) Draft 2011 Criteria Overview – released October 19, 2010 for public comment
Accountable Care Organization Proposed Payment

Medicare FFS + bonus or capitation?

“Follow the Money”

- ACO responsible for:
  - Clinical care management (clinical integration)
  - Capture data for continuum of care
  - Measure, monitor costs and quality
Are You Accountable?

The “Accountable” Delivery System

Customer Service
- Ease of access
- Patient-focused care
- "Concierge like" services
- Patient satisfaction surveys

Payer Contracting Strategies
- Pricing (what tier will you be in?)
- Collaboration on new products
- Shared savings
- Capitation

Network Operational Performance
- Robust Network vs Tight Network
- Contracts broad vs detailed
- Prove value - Cost and efficiencies
- Dashboard reporting: measure what consumers and payers value

Human Resources
- Recruiting/Training for the cultural change
- System performance expectations
- Minimize "silos" mentality

Program Development
- Centers of Excellence
- "Retail" programs
- Continuum of care
- Eliminate underperforming services

Financial Management
- Fee schedule/pools/OWA
- Detailed Flow of Funds/Actuarial Services/
- Managing bundled payments

Centralized Care Continuum Management - Quality & Reporting
- Data sources/accuracy of coding
- Care management/coordination
- Care protocols
- Internal report cards and benchmarking
- Disease management
- Point of care alerts

E-Health
- Website management
  - Patient interaction
- Medical records availability
- CPOE/Remote devices
- EHR
- Social Networks

Network Operational Performance
- Robust Network vs Tight Network
- Contracts broad vs detailed
- Prove value - Cost and efficiencies
- Dashboard reporting: measure what consumers and payers value

Are You Accountable?
Sample ACO Configuration

Accountable Care Organization

Medicare/Other Payers

$ Management Services Agreement

Physician Network
- Medical Group(s)
  - Community MDs
- Hospitals
  - Other Regional Hospitals?

Hospitals

Continuum of Care Services
- Outpatient services
- Nursing homes
- Home health
- Acute rehab
- Hospice
- Other

Joint Ventures

Infrastructure (Provided or Contracted ACO Operations)
- Information Technology
  - EMR, CPOE, PACS
  - Data warehouse
  - Reporting
- Care Management
  - Hospitalists and Intensivists
  - CMO
  - Disease management
  - Clinical protocols
  - Advanced analytics and modeling
  - Call center
  - Utilization management
  - Knowledge management
- Health Network
  - Delivery network
- Financial/Payment Systems
How Shared Savings May Evolve – What’s in it for me?

Source: Julie Lewis, Dartmouth Institute for Health Policy and Clinical Practice. Presentation, October 2009.

- **ACO Target Expenditures** $100M
  - To ACO $89M
    - $9M to ACO (50%)
    - $9M to Payer (50%)
    - $2M (2% threshold)
    - $80M to ACO in FFS Payments
  - To ACO $96M
    - $16M to ACO (80%)
    - $4M to Payer (20%)
  - To ACO $96M
    - $16M to ACO (80%)
    - $4M to Payer (20%)

- **ACO Actual Expenditures** $80M
  - To ACO $89M
    - $80M to ACO in FFS Payments
  - To ACO $96M
    - $80M to ACO in FFS Payments
    - $60M to ACO in FFS Payments
    - $20M to ACO in Partial Capitation

Simple Shared Savings

Shared Savings + Symmetrical Risk

Shared Savings + Partial Capitation
## How is the Beginning of the ACO Era Different from the HMO?

<table>
<thead>
<tr>
<th>HMO Era</th>
<th>ACO Era</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discounted Payments to Providers</td>
<td>Right Care/Right Time/Right Place</td>
</tr>
<tr>
<td>Withholds</td>
<td>Incentives/Gain-Share</td>
</tr>
<tr>
<td>Booming Economy</td>
<td>Recession</td>
</tr>
<tr>
<td>Limited Government Intervention</td>
<td>Government Pushing Down Medicare Advantage and Elevating ACOs</td>
</tr>
<tr>
<td>Assignment of Patients</td>
<td>Attribution / Relationships</td>
</tr>
<tr>
<td>Limited Systems to Implement</td>
<td>Installing Robust Systems &amp; Care Models</td>
</tr>
<tr>
<td>Prevention</td>
<td>Management of Chronic Disease</td>
</tr>
</tbody>
</table>
Clinical Integration – Original Case Studies

Advocate Health Care
- Metro Chicago Area
- 8 Hospitals
- 300,000 Capitated HMO
- 700,000 PPO patients
- 7 PHOs: 2,900 physicians

BROWN&TOLAND PHYSICIANS
- San Francisco Bay Area
- 8 Affiliated Hospitals
- 100,000 Covered PPO lives
- 190,000 HMO lives
- 1,500 physicians
- Since 1993

gripa
- Rochester, New York (Rochester General Hospital & Health System)
- 2 Affiliated Hospitals
- 115,000 lives
- 650 physicians
- Since 1996

PARTNERS HEALTHCARE
- Eastern Massachusetts
- 12 Hospitals
- 500,000 Covered Lives
- PCHI: 5,500 physician
- Since 1994 (PCHI)
ACO Demonstrations

Medicare Pilot Sites

- Carilion Clinic
  Roanoke, VA

- Norton Healthcare
  Louisville, KY

- Tucson Medical Center
  Tucson, AZ

Private Payer Pilot Sites

- HealthCare Partners
  Torrance, CA

- Anthem
  Irvine, CA
CalPERS: Piloting Accountable Care

- Integrated delivery model: Blue Shield, CHW, and Hill
- Provides coordinated care and services
- Resulting in improved quality and reduced costs
Progress To Date

**Overutilization (focus, focus, focus)**
- Hysterectomies and elective knee surgeries were revealed to be the biggest cost drivers in the region
- Hill and CHW are collaborating on evidence-based approaches to therapy and treatments to be pursued before surgery

**Preventable Readmissions (close the gaps)**
- Intensive examinations of readmission patterns
- Caregiver education

**Out-of-Network Services**
- Repatriation program identifies patients going out-of-network and brings them back in
ACO and Clinical Integration – What’s In It For…

**Hospitals?**

- Enhanced linkage and alignment with physicians
- Facilitates implementation of quality improvement initiatives
- “Branding” consistency to patients and payers
- Expand physician leadership in clinical care redesign
- Improve revenue yield: pay-for-performance, global payments

**Physicians?**

- Access to electronic tools to enhance patient care efficiency
- Improve revenue yield: pay-for-performance, global payments
- Enhance market positioning, referrals, “preferred” network
- Enhanced satisfaction with clinical delivery model
How Does the FTC Define Integration? What about Anti-trust?

The network uses mechanisms to achieve efficiencies:
- Monitors and controls costs
- Selectively chooses physician participants
- Significant investment of monetary or human capital in infrastructure

Physician Network FTC Tests for Clinical Integration:
1. Is the clinical integration “real”: authentic initiatives actually undertaken?
2. Are the initiatives of the program designed to achieve improvements in healthcare quality and efficiency?
3. Is joint contracting with fee-for-service plans “reasonably necessary” to achieve the efficiencies of the CI program?

FTC Guidance
- Opinion letter
- Consent decree
Clinical Integration Is More Than Disease Management

Beyond Disease Management

- Early Identification
- Entry in Disease Registry

Patient Outreach
- Patient Outreach Calls
- Mailed Educational Materials
- Appointment reminders
- Medication Reminders

Physician Support
- Training for staff on the latest advances and evidence-based medicine trends
- Medication identification of suboptimal options and reminders
- Healthcare technology support with access to lab test results, registries, and educational materials

Strengthened Patient Compliance And Improvement Clinical Outcomes

Source: Advocate Health 2008 Value Report
CI Model in Action

Central Data Repository

Radiology

Hospital

Specialist

Lab

Pharmacy

PCP

Portal

© 2008 Greater Rochester Independent Practice Association. All rights reserved.
Point-of-Care (POC) Alerts - Patient Specific

Managed Conditions

<table>
<thead>
<tr>
<th>Managed Condition</th>
<th>ICD-9</th>
<th>Date Diagnosed</th>
<th>Rank</th>
<th>delete</th>
<th>edit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevention</td>
<td>unspecified</td>
<td>8/30/2007</td>
<td>1</td>
<td>delete</td>
<td>edit</td>
</tr>
<tr>
<td>Diabetes</td>
<td>8/30/2007</td>
<td>2</td>
<td>2</td>
<td>delete</td>
<td>edit</td>
</tr>
<tr>
<td>Hyperlipidemia</td>
<td>6/29/2007</td>
<td>3</td>
<td>3</td>
<td>delete</td>
<td>edit</td>
</tr>
<tr>
<td>Pneumovax Candidate</td>
<td>8/30/2007</td>
<td>4</td>
<td>4</td>
<td>delete</td>
<td>edit</td>
</tr>
</tbody>
</table>

Patient Alerts

Lab

<table>
<thead>
<tr>
<th>Measure (Alert) Name</th>
<th>Last Value</th>
<th>Date Last Value</th>
<th>Patient Goal</th>
<th>Population Goal</th>
<th>Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1c</td>
<td>7.4</td>
<td>8/4/2008</td>
<td>&lt; 7</td>
<td>&lt; 7</td>
<td>1/31/2009</td>
</tr>
</tbody>
</table>

Back to Care Opportunity Grid

Actionable Alerts only

Back to Care Opportunity Grid
Physician Achievement Report Design Provider Top Level

GRIPA Connect Clinical Integration
Physician Achievement Report (PAR)

Performance Reporting for the Clinical Integration program is based on performance of the entire panel of participating physicians and provides incentives to work collaboratively to increase quality and efficiency. The Physician Achievement Report (PAR) informs each physician of his or her performance and how the physician contributes to the performance of the network.

<table>
<thead>
<tr>
<th>CI Measure</th>
<th>Your Current Rate (%)</th>
<th>Change from Prev Qtr</th>
<th>Target Rate (%)</th>
<th>Performance</th>
<th>Your Patient Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coronary Artery Disease</td>
<td>73.1 %</td>
<td></td>
<td>74.0 %</td>
<td></td>
<td>236</td>
</tr>
<tr>
<td>Diabetes</td>
<td>73.8 %</td>
<td></td>
<td>68.3 %</td>
<td></td>
<td>300</td>
</tr>
<tr>
<td>Hyperlipidemia</td>
<td>81.9 %</td>
<td></td>
<td>80.0 %</td>
<td></td>
<td>1,026</td>
</tr>
<tr>
<td>Hypertension</td>
<td>71.2 %</td>
<td></td>
<td>82.5 %</td>
<td></td>
<td>887</td>
</tr>
<tr>
<td>Prevention</td>
<td>37.3 %</td>
<td></td>
<td>66.0 %</td>
<td></td>
<td>786</td>
</tr>
</tbody>
</table>

Please direct comments and questions to: GRIPA Provider Relations 60 Carlson Rd Rochester, NY 14610
Phone: (585) 922-1525 Fax: (585) 922-0016 Email: gripa.network@rochestergeneral.org
Putting It All Together… A Equation… Can You Do It?

Guidelines
- Release to Physician Portal
- Committees SAG, CIC, BOD
- Write guideline, select measures
- Research national and local guidelines

Measure & Disease Definitions
- Test accuracy by chart review
- Obtain ICD9, CPT4 NDC, DRG codes
- Define goals, exclusions, etc.
- Research national & local definitions

Performance Management
- Blinded Review & Action Plans
- Physician Achievement Report
- Care Opportunities Report
- Point of Care Alerts

Putting It All Together…
A Equation…
Can You Do It?
Results Can Be Impressive in Parts or Whole of the System

“Driven by Best Practices and Cultural Change and Enabled by Technology”

<table>
<thead>
<tr>
<th>Category</th>
<th>Pre- PCMH Implementation</th>
<th>Post- PCMH Implementation</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrollee Preventive Health Quality Index</td>
<td>0 of 7 measures</td>
<td>7 of 7 measures</td>
<td>+700%</td>
</tr>
<tr>
<td>(HEDIS)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PCM Continuity of Care</td>
<td>56.6%</td>
<td>75.3%</td>
<td>+33%</td>
</tr>
<tr>
<td>(% of time Enrollees See regular PCM in Clinic)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access (3rd Next Available Appointment)</td>
<td>15-35 Days</td>
<td>1-3 Days</td>
<td></td>
</tr>
<tr>
<td>Network ER Visits per 100 enrollees</td>
<td>7.7</td>
<td>6.1</td>
<td>-21%</td>
</tr>
<tr>
<td>Total Annual ER Visits per 100 enrollees</td>
<td>70.1</td>
<td>42.4</td>
<td>-40%</td>
</tr>
<tr>
<td>Network Specialty Care per 100 enrollees</td>
<td>11.5</td>
<td>5.0</td>
<td>-57%</td>
</tr>
<tr>
<td>Total Specialty Care per 100 enrollees</td>
<td>66.3</td>
<td>39.5</td>
<td>-40.4</td>
</tr>
</tbody>
</table>

Medical Expense vs Community Trends
(% above/below community)

PMPM $
Agenda
Healthcare Evolution
Value Based Care Delivery
Case Studies
Charting Your Future
### Progress To Date - Yes! Starting to See the Steps

<table>
<thead>
<tr>
<th>Success Factor</th>
<th>Stage 1</th>
<th>Stage 2</th>
<th>Stage 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Enable &amp; incent member</td>
<td>Portal Access to EHR</td>
<td>Pre &amp; post care contact</td>
<td>Prevention</td>
</tr>
<tr>
<td></td>
<td>Call Center support</td>
<td>Member outreach</td>
<td>Plan for Life</td>
</tr>
<tr>
<td></td>
<td></td>
<td>E-consults</td>
<td>Remote monitoring</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Incentive programs</td>
<td>Social Networks (by disease, provider etc)</td>
</tr>
<tr>
<td>II. Medical Management</td>
<td>Care/Case management</td>
<td>Start to Centralize CM</td>
<td>Full functioning care management division across continuum</td>
</tr>
<tr>
<td></td>
<td>Provider Portals</td>
<td>Common Guidelines across continuum</td>
<td>Disease management</td>
</tr>
<tr>
<td></td>
<td>Prompts &amp; Alerts</td>
<td>Patient centered medical home</td>
<td>Quality of Life</td>
</tr>
<tr>
<td>III. Clinical Information Communications</td>
<td>View-only access</td>
<td>Clean &amp; push key data to providers</td>
<td>Real-time sharing across all venues</td>
</tr>
<tr>
<td></td>
<td>Web-based tools</td>
<td>Dynamic Patient Info</td>
<td>Patient access to EHR</td>
</tr>
<tr>
<td></td>
<td>Referral-based</td>
<td>Guidelines Embedded</td>
<td>Social Network</td>
</tr>
<tr>
<td>IV. Alerting, Quality, Care Consumption, Network &amp; Provider Reporting</td>
<td>EHR (meaning use Stage 1)</td>
<td>Real-time push of alerts and referrals</td>
<td>Real-time - dashboard/desktop, ad hoc reporting and provider &amp; pop reporting</td>
</tr>
<tr>
<td></td>
<td>Integration Committee Structure operational</td>
<td>EHR (meaning use Stages 3 and 4)</td>
<td></td>
</tr>
<tr>
<td>V. Predictive Modeling and Analytics; Reporting; and support</td>
<td>Patient focused</td>
<td>Population focused by segment</td>
<td>Social and network data</td>
</tr>
<tr>
<td></td>
<td>Episode/Encounter focused data</td>
<td>Continuum of care data</td>
<td>Behavioral analytics</td>
</tr>
<tr>
<td></td>
<td>Retrospective</td>
<td>Predictive analytics</td>
<td>Real-time Reporting to all care givers and patient, individual &amp; pop</td>
</tr>
<tr>
<td></td>
<td>Clinical and financial</td>
<td></td>
<td></td>
</tr>
<tr>
<td>VI. Risk, Revenue and reward Management</td>
<td>Account across the continuum of care</td>
<td>Enhance network performance</td>
<td>Bundled Payments; Gain Share and Capitation</td>
</tr>
<tr>
<td></td>
<td>Membership data management</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Healthcare Reform Strategy Check List

1. Reduce operating costs
   A. Overhead
   B. Clinical resource consumption

2. Prepare for value based payment – i.e. bundled payments
   A. Orthopedics and cardiac service lines
   B. Health plan contracts (HMO,PPO), Medicare Pilots
   C. Must conduct an assessment now, engage hospital, physicians & ancillary service across continuum

3. Prepare for an Accountable Care Organization (delivery system)
   A. Assess your market position & your organization’s gaps
   B. What is your physician or hospital alignment strategy?
   C. What will your competitors (medical group, IPA, and hospitals) do?
4. Invest “smart” in IT & Care Models
   A. EMR – meet meaningful use
   B. Portals – Provider, Patient…Connect!
   C. PCMH, Co-Mgt, Bundled Payments, CI & ACO

5. Assess your market, stay close to payer activity, follow the money, help set the rules
   A. Meet with health plans & large brokers
   B. Identify & begin work with self-funded employers (including you)
   C. Know your state’s plans
   D. Know and Participate in the Federal and national accrediting body regulations and rule processes
# ACO Action Plan – Where are you and What should you do?

## Invest in Capabilities

<table>
<thead>
<tr>
<th>If you have:</th>
<th>You should:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aligned physicians</td>
<td>Perform a gap analysis of competencies and resources</td>
</tr>
<tr>
<td>Limited IT infrastructure</td>
<td>Identify strategies for filling the gaps (i.e., funding from payers, private equity, or developing internally)</td>
</tr>
<tr>
<td>Not operated in a managed care environment</td>
<td>Re-examine if the organization will need a strategic partner (i.e., larger hospital/health system in the future with capital, stronger market position)</td>
</tr>
<tr>
<td></td>
<td>Enhance investments in IT, data analytics, managed care expertise, physician alignment</td>
</tr>
</tbody>
</table>

## Seize the Opportunity

<table>
<thead>
<tr>
<th>If you have:</th>
<th>You should:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care physician integration with the hospital</td>
<td>Examine your market and organization’s position</td>
</tr>
<tr>
<td>Organized for and experience with managed care</td>
<td>Seize the opportunity to differentiate or grow market share</td>
</tr>
<tr>
<td>Geographic coverage/significant defined population</td>
<td>Pursue ACO strategies with private/commercial payers</td>
</tr>
<tr>
<td>Relationships with providers along the continuum of care</td>
<td>Build upon critical mass to ensure adequate geographic coverage</td>
</tr>
<tr>
<td></td>
<td>Develop an ACO-oriented culture</td>
</tr>
</tbody>
</table>

## Evaluate Your Future Direction

<table>
<thead>
<tr>
<th>If you have:</th>
<th>You should:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fragmented physician relationships</td>
<td>Consider the need for a performance improvement initiative</td>
</tr>
<tr>
<td>Limited IT infrastructure and data analytic capability</td>
<td>Evaluate your organization’s long-term sustainability in a reformed payment system</td>
</tr>
<tr>
<td>High costs</td>
<td>Re-examine if the organization will need a strategic partner (i.e., larger hospital/health system in the future with capital, stronger market position)</td>
</tr>
<tr>
<td>Secondary market position</td>
<td>Consider significant investments in IT, engaging physicians in an integrated system</td>
</tr>
</tbody>
</table>

## Leverage Capabilities

<table>
<thead>
<tr>
<th>If you have:</th>
<th>You should:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly aligned, affiliated physicians</td>
<td>Maintain focus on performance improvement</td>
</tr>
<tr>
<td>Infrastructure to support IT, medical management, and market dominance</td>
<td>Evaluate how the organization can reposition itself to be more efficient and improve quality</td>
</tr>
<tr>
<td>High costs requiring performance improvement</td>
<td>Perform make/buy analysis as a mechanism to advance more quickly toward an ACO model</td>
</tr>
<tr>
<td>Access to capital</td>
<td></td>
</tr>
<tr>
<td>Organizational culture that is willing to adapt</td>
<td></td>
</tr>
</tbody>
</table>

---

**ACO Capabilities**

**Limited**

- THE CAMDEN GROUP

---

**Comprehensive**

- Comprehensive

---
Moving to Healthcare Based on Value - Three Choices

- Change - Become an Accountable Care Organization
- Change - Become one of the most important value producing providers in an Accountable Care Organization(s)
- Believe this is all going to be dismantled and go about business as usual
“This time like all times, is a very good one if you know what to do with it.”

– Emerson
The National Accountable Care Organization Summit

The Leading Forum on the Accountable Care Organizations (ACOs) and Related Delivery System and Payment Reform