The UNC Health Care System & BlueCross BlueShield of North Carolina
Model Medical Practice:
A Blueprint for Successful Collaboration
Session Overview

Many forward-thinking organizations are forging ahead with new models of clinically-integrated systems to achieve high quality and promote downstream cost savings. The Model Medical Practice under development by the UNC Health Care System and BlueCross and BlueShield of North Carolina is one prominent example of the key role that collaboration by providers and health plans will play in shaping the future direction of our health care system. This session will take you behind the scenes of the negotiating room to unveil the practical challenges and critical issues in building new pathways of innovation.
Part I:
  Medicare Shared Savings Program – Bureaucratic Misstep or Catalyst for Change?
Part II:
  Identifying Key Antitrust Considerations
Part III:
  The UNCHCS and BCBSNC Model Medical Practice
Part IV:
  Open Question and Answer Session on the Practical Challenges and Critical Issues of the UNCHCS and BCBSNC Collaboration
Part I:
Medicare Shared Savings Program –
Bureaucratic Misstep or
Catalyst for Change?

Jeffrey Ruggiero, Arnold & Porter
Physicians, particularly those who are in Primary Care, and specifically those in a solo or a small group practice, of two or three physicians, now find themselves in practice crisis.

“Healing is an art, medicine is a profession, health care is a business.”

Wise Observer
HOSPITAL-PHYSICIAN ALIGNMENT
DEJA VU ALL OVER AGAIN?

- 1990’s
  - Response to rise of HMOs - prospect of capitated payments
  - Predominantly PHO strategies - vehicle for joint managed care contracting and reducing utilization of services
  - Hospital purchases of physician practices

- WHYSTRATEGIES FAILED
  - Failure to recognize differences between managing physicians and managing other hospital staff
  - Hospital-dominated management - leaving physicians in the cold
  - Specialty physicians lacked motivation to affiliate
  - Hospitals guaranteed physician compensation while neglecting to tie payments to productivity
  - Commercial health plans preferred to negotiate separately with hospitals and physicians
  - Loose affiliations lacked sufficient integration - relationships disintegrated
HOSPITAL-PHYSICIAN ALIGNMENT
DEJA VU ALL OVER AGAIN? (cont’d)

WHAT’S DIFFERENT NOW?

• Today’s strategies driven by harsh economic realities

• Hospitals
  • Intense competition - reduced referrals
  • Shrinking market share
  • Deep cuts in Federal and State funding

• Physicians
  • Eroding income
  • Increasing practice management expenses
  • Inability to raise capital for upgrading facilities, equipment and IT

• Market Realities/Legislation Pushing Hospitals and Physicians to Join Forces
Payor/Provider Collaborations

- Payors Buying Physicians
  - Four of the five largest insurers increased physician holdings in the past year
  - UnitedHealth Group – buying medical groups and launching physician management companies
  - CIGNA Medical Group launched Care Today clinics in 2006 in Arizona
  - Humana purchased Concentra urgent-care system based in Texas in December 2010
  - Well Point purchased CareMore Health Group (health plan operator that owns 26 clinics)

- Payors Buying Hospitals
  - Highmark Acquisition of West Penn Allegheny (5 hospitals)

1990’s

- Humana’s hospital acquisition strategy (76 hospitals nationally) resulted in spinoff to Galen Health Care in 1993
- Physicians refused to refer patients to Humana hospitals based on objections to certain managed care practices
MEDICARE SHARED SAVINGS PROGRAM - SECTION 3022 OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (“AFFORDABLE CARE ACT” OR “ACA”)

- No later than January 1, 2012, the HHS Secretary must establish a shared savings program specifically relating to Accountable Care Organizations (“ACOs”)

- What is an ACO?
  - Organization of health care providers that agrees to be accountable for the quality, cost, and overall care of assigned Medicare beneficiaries who are enrolled in the traditional fee-for-services program

- Eligible Organizations
  - Physicians in group practice arrangements
  - Physicians in networks of practices
  - Partnerships or joint venture arrangements between hospitals and physicians
  - Acute care hospitals employing physicians
  - Rural Health Clinics
  - Federally Qualified Health Centers
MEDICARE SHARED SAVINGS PROGRAM - SECTION 3022 OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT ("AFFORDABLE CARE ACT" OR "ACA") (cont’d)

- **Shared Savings**
  - Based on 12-month period
  - Upon satisfaction of quality standards, eligible to receive a percentage (50% one-sided model / 60% two-sided model) of any savings
  - Actual per capita expenditures of assigned beneficiaries must be a sufficient percentage below specified benchmark
  - Benchmark for each ACO will be based on most recent 3 years of per-beneficiary Parts A and B expenditures for fee-for-service beneficiaries assigned to ACO
  - Benchmark for each ACO will be adjusted for certain beneficiary characteristics and other factors, and updated by the projected absolute amount of growth in national per capita expenditures for Part A and B

- **Quality Performance Standards**
  - 33 Measures - Includes clinical processes and outcomes, patient experience, and utilization benchmarks
ACO Participation Requirements

- Formal legal structure and common governance to receive and distribute shared savings
- Sufficient number of primary care Physicians for a minimum of 5,000 beneficiaries
- Written agreement with CMS for a minimum 3-year term
- Sufficient information regarding participating ACO professionals to support beneficiary assignment and the determination of shared savings payments
- Leadership and management structure that includes clinical and administrative systems
- Defined processes to:
  - Promote evidence-based medicine
  - Report necessary data to evaluate quality and cost measures
  - Coordinate care
  - Demonstrate satisfaction of patient-centeredness criteria
HHS/CMS ESTIMATES

- 75% of Medicare Beneficiaries are in Fee-for-Service
- 50 to 270 ACOs (4 years) (revised from 75 to 150 / 3 years)
- 1 to 5 million Medicare beneficiaries (revised from 1.5 to 4 million / 3 years)
- Estimated aggregate bonus payments of $1.31 billion (4 years) (revised from $800 million / 3 years)*
- No penalties for first agreement term (revised from $40 million / 3 years)*
- Infrastructure costs to establish new ACO-average $580,000
- Average of $1.27 million in ongoing annual ACO operating costs
- $470 million estimated Federal Government (Medicare) savings (4 years) * (revised from $510 million/ 3 years)
  - 2012 $20 million (revised from $100 million)
  - 2013 $90 million (revised from $210 million)
  - 2014 $160 million (revised from $200 million)
  - 2015 $190 million (revised from $200 million)

* Median estimates.
- Outcomes could differ “substantially” from the median estimate
- Could result in lower Medicare Advantage Payments and lower Part B premiums (Not included in estimates)
# Proposed Rule versus Final Rule for Accountable Care Organizations (ACOs) in the Medicare Shared Savings Program

<table>
<thead>
<tr>
<th>Topic</th>
<th>Proposed Rule</th>
<th>Modifications in Final Rule</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transition to risk in Track 1</td>
<td>ACOs could choose from two tracks, each entailing a 3-year agreement. Track 1 would comprise 2 years of one-sided shared savings with a mandatory transition in year 3 to a performance-based risk under a two-sided model. Track 2 would comprise 3 years all under the two-sided model.</td>
<td>Remove two-sided risk from Track 1. Two tracks would still be offered for ACOs at different levels of readiness, with one providing higher sharing rates for ACOs willing to also share in losses.</td>
</tr>
<tr>
<td>Prospective vs. Retrospective</td>
<td>Retrospective assignment based on utilization of primary care services, with prospective identification of a benchmark population.</td>
<td>A preliminary prospective-assignment method with beneficiaries identified quarterly; final reconciliation after each performance year based on patients served by the ACO.</td>
</tr>
<tr>
<td>Proposed measures to assess quality</td>
<td>65 measures in 5 domains, including patient experience of care, utilization claims-based measures, and measures assessing process and outcomes. Pay for full and accurate reporting first year, pay for performance in subsequent years. Alignment of proposed measures with existing quality programs and private-sector initiatives.</td>
<td>33 measures in 4 domains. (Note: Claims-based measures not finalized to be used for ACO-monitoring purposes) Longer phase-in measures over course of agreement: first year, pay for reporting; second year and third year, pay for reporting and performance. Finalize as proposed.</td>
</tr>
</tbody>
</table>
## Proposed Rule versus Final Rule for Accountable Care Organizations (ACOs) in the Medicare Shared Savings Program

<table>
<thead>
<tr>
<th>Topic</th>
<th>Proposed Rule</th>
<th>Modifications in Final Rule</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sharing savings</strong></td>
<td>One-sided risk model: sharing beginning at savings of 2% with some exceptions for small, physician-only, and rural ACOs. Two-sided Risk Model: sharing from first dollar.</td>
<td>Share on first dollar for all ACOs in both models once minimum savings rate has been achieved.</td>
</tr>
<tr>
<td><strong>Start date</strong></td>
<td>Agreement for 3 years with uniform annual start date; performance years based on calendar years.</td>
<td>Program established by January 1, 2012; first round of applications are due in early 2012. First ACO agreements start 4/1/2012 and 7/1/2012. ACOs will have agreements with a first performance “year” of 18 or 21 months. ACOs starting 4/1/2012 and 7/1/2012 have option for interim payment if they report CY 2012 quality measures. ACO must report quality measures for CY 2013 to qualify for first-performance year shared savings.</td>
</tr>
<tr>
<td><strong>Electronic health record (EHR) use</strong></td>
<td>Aligning ACO requirements with HER requirements, 50% of primary care physicians must be defined as meaningful users by start of second performance year.</td>
<td>No longer a condition of participation. Retained HER as quality measure but weighted higher than any other measure for quality-scoring purposes.</td>
</tr>
</tbody>
</table>
Proposed Rule versus Final Rule for Accountable Care Organizations (ACOs) in the Medicare Shared Savings Program

<table>
<thead>
<tr>
<th>Topic</th>
<th>Proposed Rule</th>
<th>Modifications in Final Rule</th>
</tr>
</thead>
</table>
| Assignment process          | One-step assignment process: beneficiaries assigned on the basis of a plurality of allowed charges for primary care services rendered by primary care physicians (internal medicine, general practice, family practice, and geriatric medicine). | Two-step assignment process:  
  • Step 1: for beneficiaries who have received at least one primary care service from a physician, use plurality of allowed charges for primary care services rendered by primary care physicians.  
  • Step 2: for beneficiaries who have not received any primary care services from a primary care physician, use plurality of allowed charges for primary care services rendered by any other ACO professional. |
"I've seen this before: Combustion due to extreme resistance to change."
Part II:
Identifying Key Antitrust Considerations

Asim Varma, Arnold & Porter
Overview

- Based on a few, very simple statutes
  – Sherman Act §§1 and 2
- Protects competition, *not competitors*
- Requires fact-specific inquiry
Key Antitrust Issues

- Market presence
- Effect on competition
- Establish a justification
- Implement safeguards
Competitors and Market Presence

- Identify every market affected
- Identify geographic market
- Estimate market share
- Assess market power
Justification for Venture

- Effect on prices
- New service
- Effect on quality
- More efficient delivery
- Can objectives be achieved independently?
Foreclosure

- Access to patients
- Access to providers
- Exclusivity
Information Exchange

- Spillover
- Competitively sensitive information
- Safeguards
ACO Alternative:

- Financial integration
- Clinical integration
- ACOs complying with CMS guidelines
  - Rule of reason applies
Measuring Market Share

- Common services – MSC/MDC
- Primary Service Areas – lowest number contiguous postal zip codes from which ACO draws at least 75% of its patients.
- Calculate share
ACO Alternative: Safe Zone

- Combined share less than 30%
  (with rural exception)
- Dominant participation
- Exclusivity
- Voluntary 90-day review
Conduct to Avoid:

- Contractual terms discourage payers from incentivizing patients to choose certain providers.
- Conditioning the ACO’s services on a payer’s purchase of other services from providers outside the ACO and vice versa.
- Making the ACO’s participants exclusive to the ACO.
- Restricting payer’s ability to make available to enrollees information similar to the Shared Success performance measures.
- Sharing among the ACO’s provider participants competitively sensitive data such as pricing outside the ACO.
Part III: UNCHCS and BCBSNC Model Medical Practice

Ted Lotchin, Arnold & Porter
BlueCross BlueShield of North Carolina

- Largest health insurer in North Carolina and one of the 25 largest health insurers in the nation - 4,600 employees serving over 3.7 million customers
- Serving customers for almost 80 years
- Commitment to quality and patient satisfaction
- Commitment to community services - BCBSNC Foundation invested almost $70 million in local communities in 2010
The UNC Health Care System

- Chartered to provide patient care, educate physicians and other providers, conduct research, and promote the health and well-being of the citizens of North Carolina
- U.S. News & World Report: Best Hospitals 2010-11
- Almost 40,000 inpatients and 800,000 outpatients each year
- UNC Hospitals - 803 licensed beds
- UNC Physicians & Associates - 1,100 UNC School of Medicine faculty members
- Triangle Physician Network - Almost 100 employed physicians
Changing Landscape

- Hospital acquisitions of physician practices
- Health insurer acquisitions of provider networks
- Federal focus on care coordination and disease management
- Alternative reimbursement mechanisms to change provider incentives
BCBS Experience

- BCBSNC
  - Blue Quality Physician Program
  - Highest level of NCQA accreditation (HMA, POS, and PPO)
- BlueCross BlueShield of Massachusetts Alternative Quality Contract
- BlueShield of California Pilot Program
UNC Health Care System Experience

- NCQA PCMH Recognition
- Carolina ACCESS
- Town of Chapel Hill Wellness@Work
- Community Based Clinics
- Triangle Physician Network
Partners in innovation and service

- Develop new relationship between UNC Health Care and BCBSNC
- Explore financing and delivery models that provide greater value in the changing healthcare environment
- Create clinical laboratories to test new models and concepts
- Gain hands-on experience with ACO principles
- Improve the health and wellbeing of North Carolinians
First collaboration is Carolina Advanced Health

- Clean-sheet redesign of primary care office to develop an integrated medical home
- Test a fundamentally new model for organizing, funding and delivering “primary care”
- Build evidence-based care model beyond Level 3 PCMHs
- Align financial incentives to shared costs and savings
- Design with a patient-centered orientation and team approach
“Do Something Significant”

- Improve access, delivery, quality, and efficiency by coordinating care across settings
- Promote partnership and integration across industries
- Assure sustainability, suitability, and scalability in rural and urban settings
Who will Carolina Advanced Health serve?

- BCBSNC members only
- 5,000 patients
- Enriched with chronically-ill adult population
  - Coronary Artery Disease
  - Hypertension
  - Diabetes
  - Obstructive Lung Disease
  - Depression
  - Asthma
- For three-year pilot beginning on December 1, 2011
What makes Carolina Advanced Health different?

**Access and Convenience**
- Extended hours
- Open scheduling
- Telehealth visits
- Small patient-to-provider ratio

**Effective Encounters**
- Pre-visit planning
- Decision support
- Evidence-based protocols
- Outcome orientation

**Self-Management Support**
- Lifestyle / health coach
- Decision aids and educational materials
- Home monitoring

**One-Stop Shopping**
- Primary Care
- Behavioral Health
- Pharmacist
- Phase 2 – select Specialists

**Technological Support**
- Sharing of claims data
- Disease registries
- Patient risk stratification

**Coordination of Care**
- Case management
- Transition-of-care program
Collaboration offers increased value for stakeholders

**Patient**
- Improved health and wellbeing
- Better, more confident self-management of chronic conditions

**Provider**
- More time to fully engage patients in their care
- Focus on outcomes
- Information and tools to provide quality care

**Payer**
- Demonstrate leadership in changing the healthcare system
- Aligning incentives
- Creating a sustainable, replicable model
Carolina Advanced Health - Lessons Learned

- Executive sponsorship and direction with physician leadership
- Building on previous relationships and partnerships
- Shifting the negotiation paradigm to move past historical relationships
- Moving forward while worrying about the details
- Gaining confidence of internal and external stakeholders
Lessons Learned

- Defining and agreeing on the roles and operational responsibilities for each partner
- Educating each partner on unique business practices
- Navigating state and federal regulatory obstacles
- Designing and implementing new financing models
- Strategies for reducing administrative costs
Part IV: Question and Answer Session

Ron Smith, BlueCross BlueShield of North Carolina
Kevin FitzGerald, UNC Health Care System
Thank You

Jeffrey Ruggiero, Arnold & Porter  
Jeffrey.Ruggiero@aporter.com

Asim Varma, Arnold & Porter  
Asim.Varma@aporter.com

Ted Lotchin, Arnold & Porter  
Theodore.Lotchin@aporter.com

Ron Smith, BlueCross BlueShield of North Carolina  
Ron.Smith@bcbsnc.com

Kevin FitzGeral, UNC Health Care System  
Kevin_fitzgerald@med.unc.edu