Agenda

- Accountable care economics
- Impact on specialists
- Transparency
- Demonstrating value
- Strategic considerations and alliances

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Accountable Care Economics

Transitional model

TODAY: Volume-based reimbursement

→ *Accountable care*

TOMORROW: Value-based reimbursement

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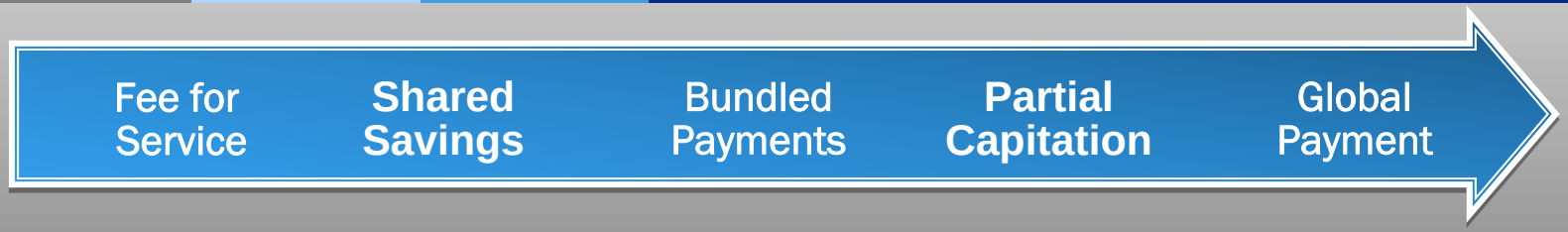
How Will You Be Reimbursed



Reactive	Focused	Predictive
Visitor	Patient	Person
Symptomatic	Episode	Overall Health
Acute Needs	Most Common Conditions	Community Health Characteristics
Services & Supplies	Packaged Treatments	Management of Well Being
Unit Based	Efficiency Based	Outcome Based
No Financial Risk	Partial Financial Risk	Full Financial Risk

Accountable Care Economics

- Begin shifting risk from payer to provider
- ACO is risk management vehicle
- ACO risk = total FFS payments – benchmark
  - Held accountable for quality of care by performance standards
- HMO risk = provider cost – capitated payment

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Accountable Care Economics

- Actual total FFS payments
  - Payer's actual total payments for specified services provided to identified patient population during defined time period
  - Not limited to goods and services furnished by ACO participants
- Benchmark
  - Predetermined target spend for exact same services, population, and time period
  - Typically based on historical data

Accountable Care Economics

- Performance standards
  - Predetermined broad-ranging quality measures
  - Overall patient care – not limited to ACO participants
  - Payment and continued participation tied to overall ACO performance

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Accountable Care Economics

- Sharing risk
  - Individual ACO participants share risk using formula approved by ACO governance
  - Incentives to maximize savings and achieve performance standards
  - Tension with maintaining FFS payments

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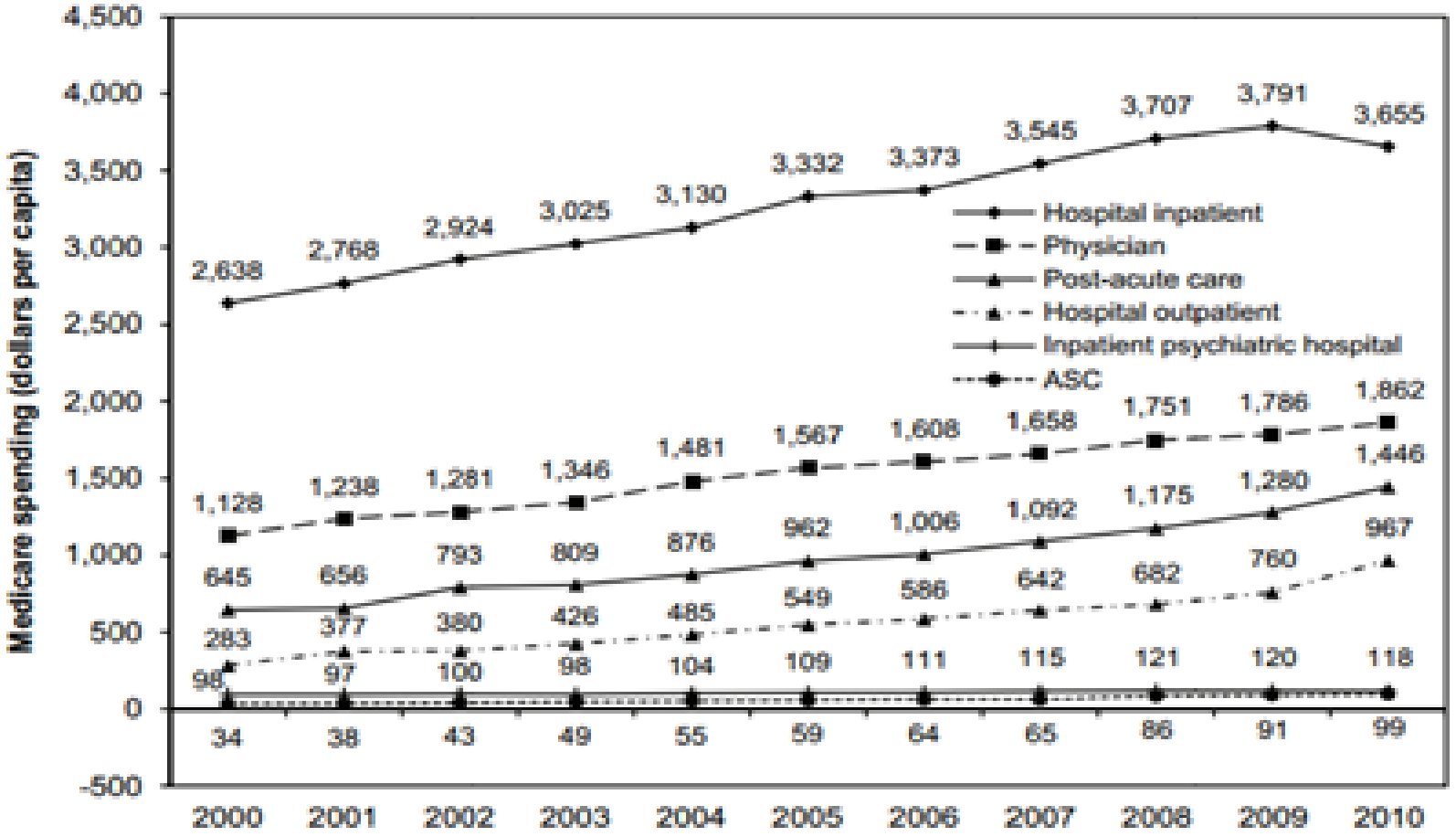
Accountable Care Economics

- Redistribution
  - Physician-only ACO shares upside risk from reduced institutional care
  - PCP-only ACO shares upside risk from reduced institutional care AND specialist care
- Realistic?
  - Non-participants do not share incentives for efficiency and quality
  - Smaller pool to share downside risk
- MedPAC Data Book: Healthcare Spending and Medicare Program (June 2012)

Per Capita Medicare Spending Among FFS Beneficiaries, by sector, 2000-2010



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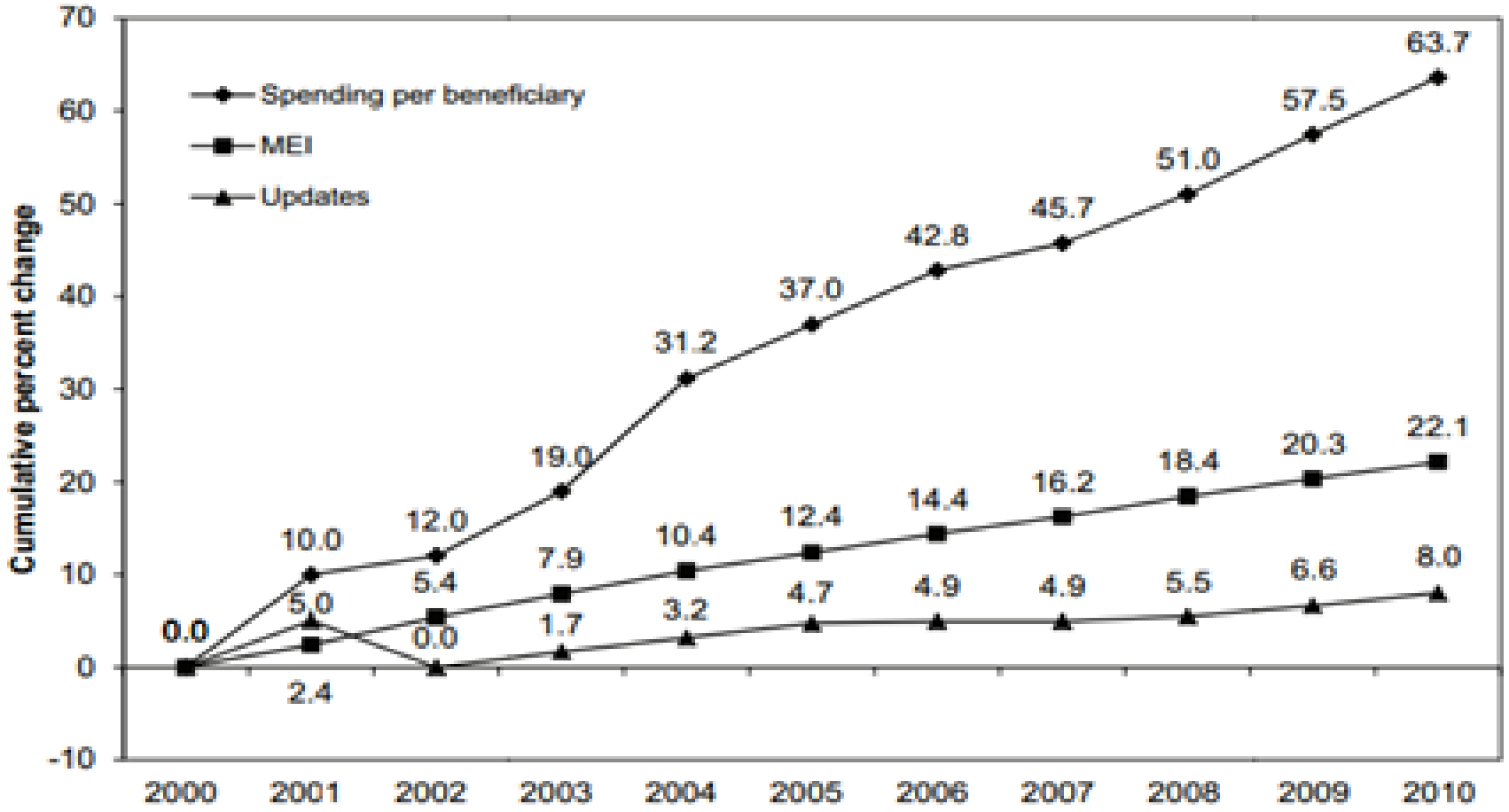
Volume Growth has Raised Physician Spending more than Input Prices and Payment Updates



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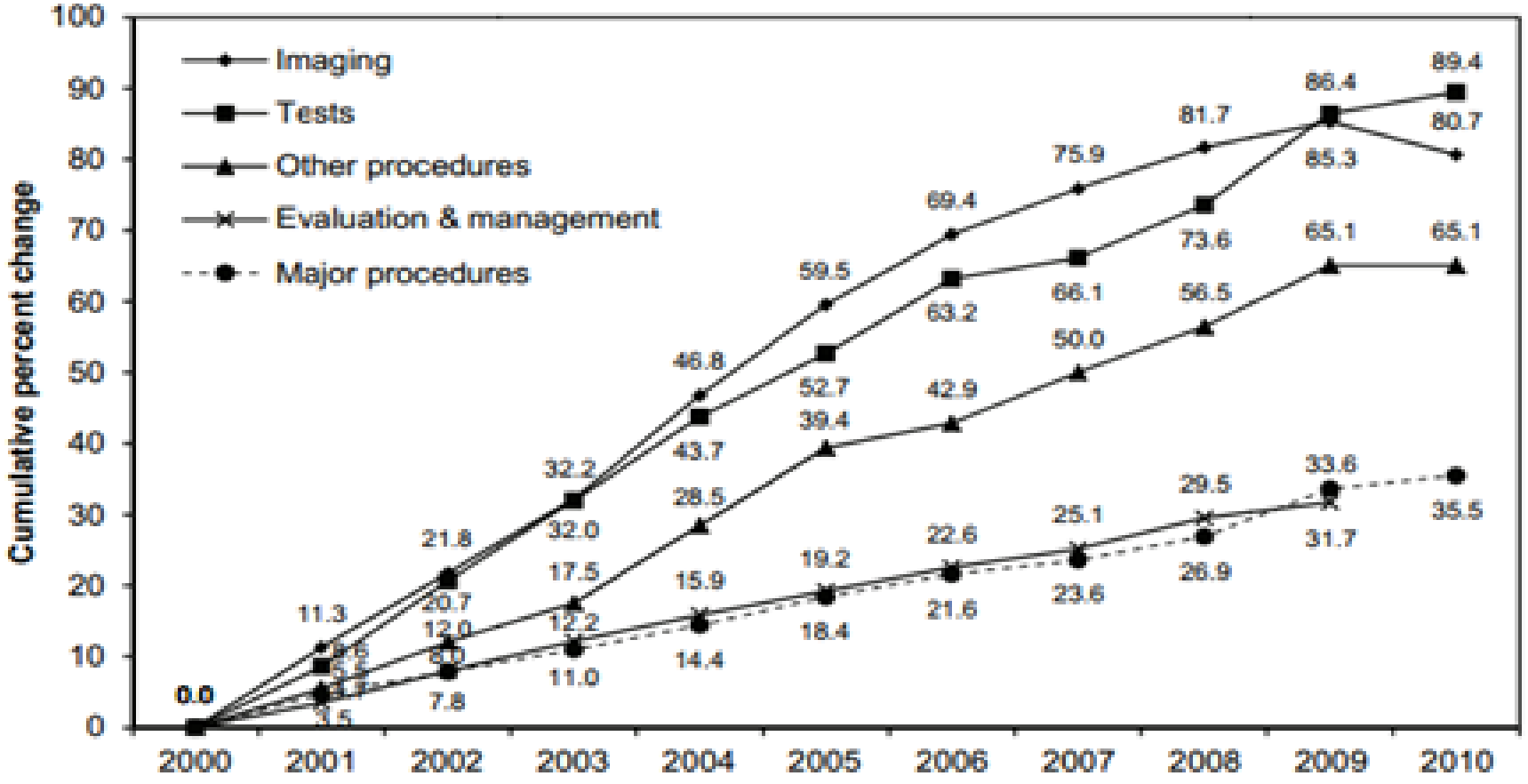
Growth in Volume of Physician Fee Schedule Services per Beneficiary, 2000-2010



Impact on Specialists

- PCPs in the driver's seat
- Value-based decision-making
  - Team members selected on basis of demonstrated cost and quality
- Shift from maximizing touches to building broader patient base
- Risk stratification and care management

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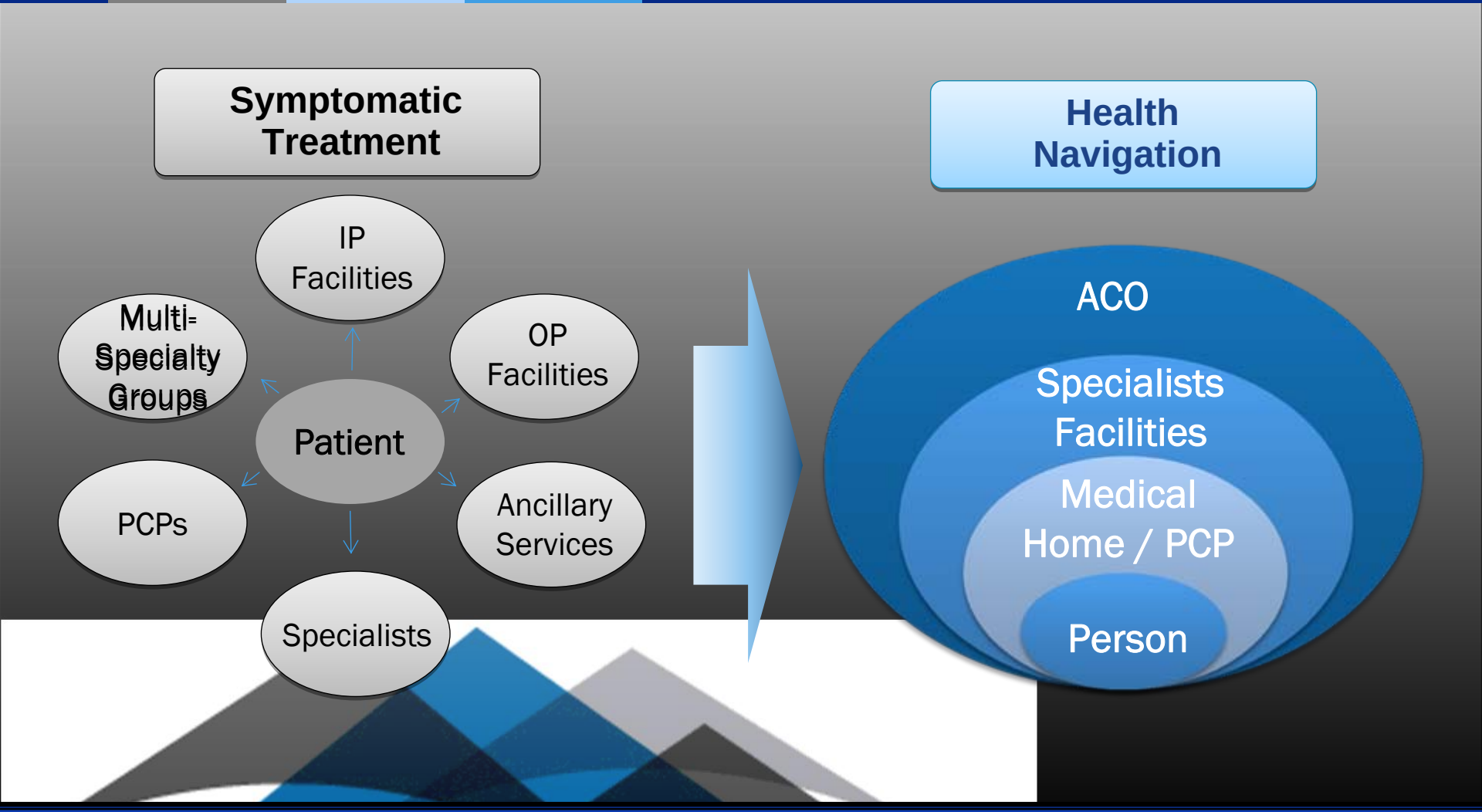
Transitioning to Healthcare Navigation



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How Will You Be Measured

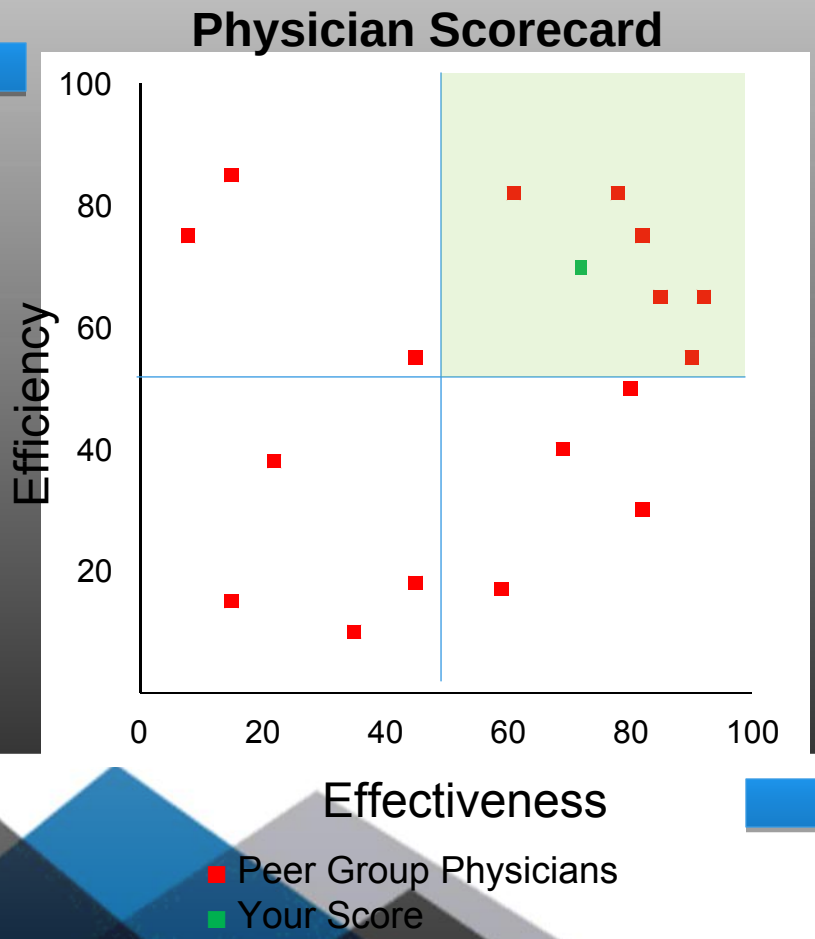
- ACO isn't just an acronym anymore
- Revenue is becoming contingent upon performance not just volume & cost
- Payer revenue is directly impacted by provider performance – provider reimbursement changing to reflect payer revenue metrics

Payer Segment	Cost	Quality	Experience /Satisfaction	Risk Stratification	# of Lives
FFS Medicare	2015	2015	2015	2015	
Medicare Adv	✓	✓	✓	✓	✓
MSSP – Medicare ACO	✓	✓		✓	✓
Medicaid	VARIES BY STATE				
Commercial ACO	✓	✓	✓	✓	✓

How Will You Be Measured Overall - Payers & Peers

Cost Efficiency

- Cost performance
- Comparing episode costs to target
- Comparison to prior years and to peers
- Expected costs are risk adjusted
- Measures such as Admissions, ER Visits, Office Visits, Scripts



Clinical Effectiveness

- Quality performance
- Applicable to specialty
- % of patients receiving all recommended care
- Current and past
- Performance vs peers
- Preventative & chronic

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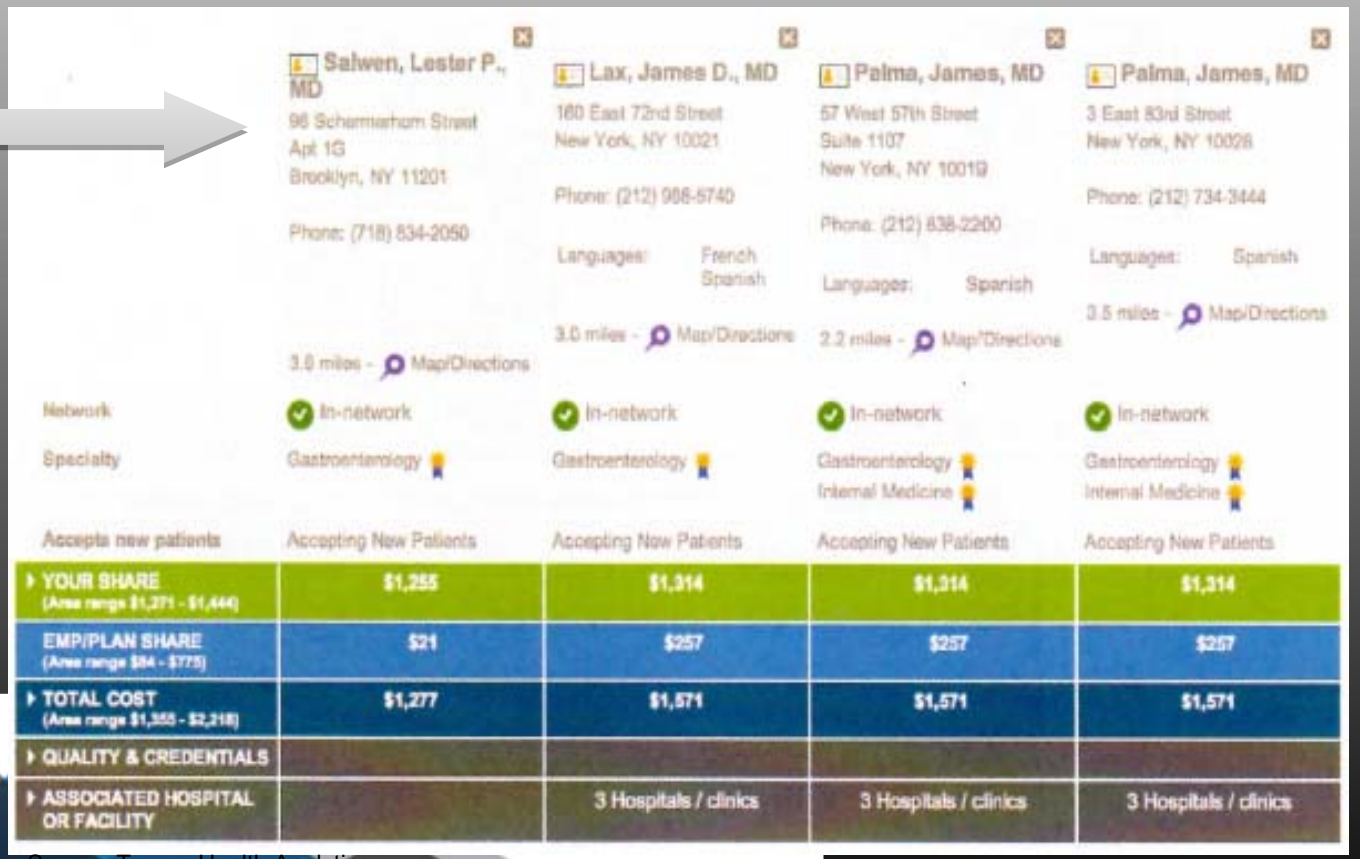
How Will You Be Measured Overall - Member

Treatment Cost Calculator

- Specialty and Region Specific Provider Comparison
- Customized calculations to compare actual cost to member
- Includes quality measures



	Salwen, Lester P., MD	Lax, James D., MD	Palma, James, MD	Palma, James, MD
	96 Schermerhorn Street Apt 1G Brooklyn, NY 11201	160 East 72nd Street New York, NY 10021	57 West 57th Street Suite 1107 New York, NY 10019	3 East 83rd Street New York, NY 10028
	Phone: (718) 834-2050	Phone: (212) 988-5740	Phone: (212) 838-2200	Phone: (212) 734-3444
		Languages: French Spanish	Languages: Spanish	Languages: Spanish
	3.0 miles - Map/Directions	3.0 miles - Map/Directions	2.2 miles - Map/Directions	3.5 miles - Map/Directions
Network	In-network	In-network	In-network	In-network
Specialty	Gastroenterology	Gastroenterology	Gastroenterology, Internal Medicine	Gastroenterology, Internal Medicine
Accepts new patients	Accepting New Patients	Accepting New Patients	Accepting New Patients	Accepting New Patients
YOUR SHARE (Area range $1,271 - $1,444)	$1,255	$1,314	$1,314	$1,314
EMP/PLAN SHARE (Area range $84 - $775)	$21	$257	$257	$257
TOTAL COST (Area range $1,355 - $2,218)	$1,277	$1,571	$1,571	$1,571
QUALITY & CREDENTIALS				
ASSOCIATED HOSPITAL OR FACILITY		3 Hospitals / clinics	3 Hospitals / clinics	3 Hospitals / clinics

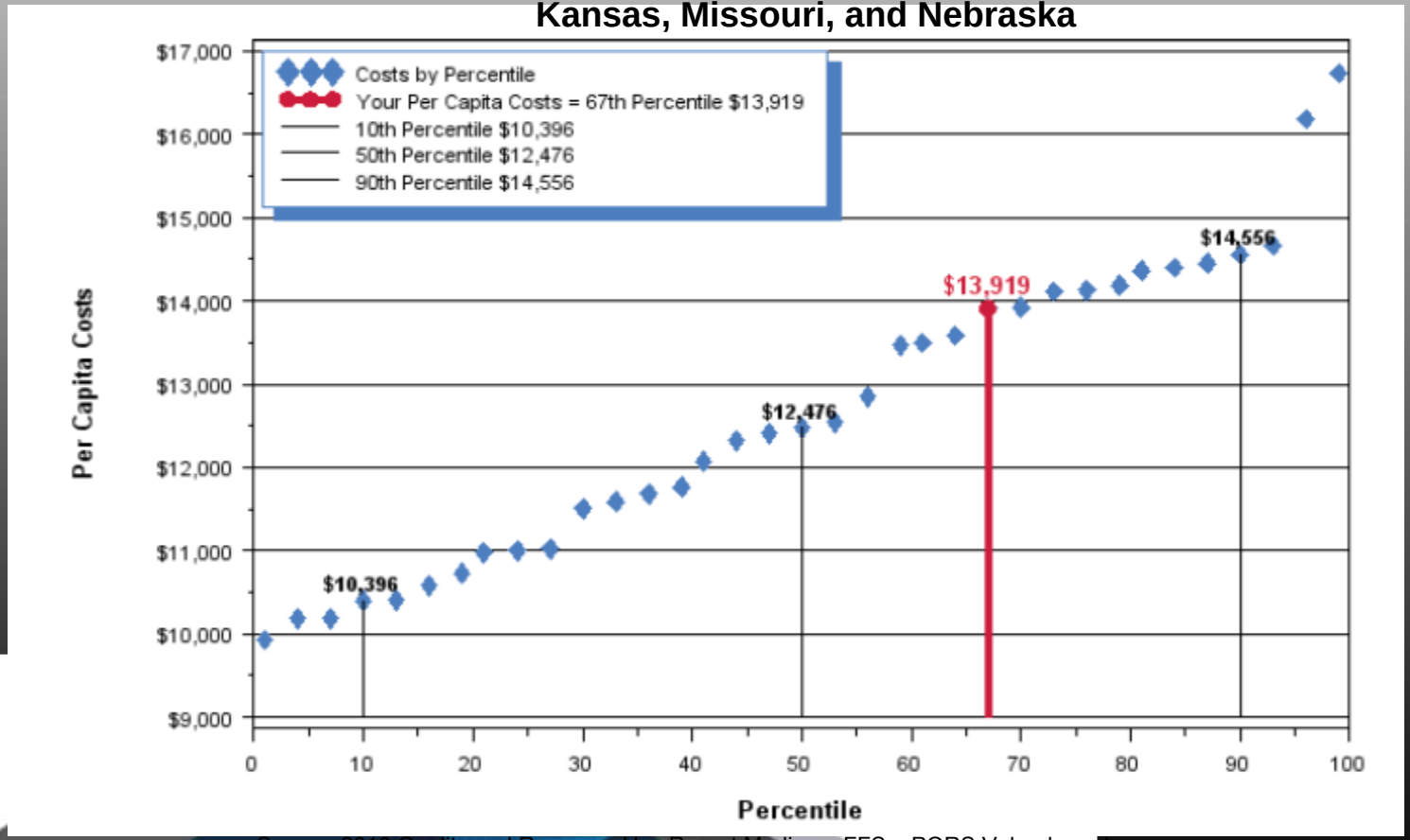
Source: Truven Health Analytics

How Will You Be Measured - Cost

- **Compared to Nation, Region, Peers, etc.**
- **Total Cost of Care/Per Capita vs Benchmark (Risk Adjusted) – Region & Peers**
- **Cost of Care by Category**
  - Medicare Part A & Part B
- **Cost of Care by Setting**
  - E&M, Procedures, I/P & O/P Facility Svcs, Ambulatory Svcs, Post-Acute Care, etc
- **Cost of Care by Episode**
- **Cost of Care by Procedure**
- **Level of Provider Involvement**
  - Total Cost
  - Total Claims Submitted
    - MSSP - Attributed based on E&M
    - Value-based Medicare FFS (PQRS) beginning 2015
      - Directed (35% or more of all outpatient E&M visits)
      - Influenced (<35% but >20% of professional costs)
      - Contributed (<35% and ≤ 20%)
  - Total Lives
  - Total E&M / E&M code set

Cost Report Sample – Total per Capita Percentile Comparison of "Directed" Care

Distribution of the 2010 Total Per Capita Costs of Patients Whose Care Was Influenced by Physicians in Your Specialty in Iowa, Kansas, Missouri, and Nebraska



Source: 2010 Quality and Resource Use Report Medicare FFS – PQRS Value-based

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How Will You Be Measured - Quality

- **Compared to Nation, Region, Peers, etc.**
- **Predetermined Measures – HEDIS, etc**
- **Specialty Specific**
- **Care Domain**
- **Ability to Report Data**
- **Significant Financial Impact to Party "At Risk" Financially**

Measure Domain	MSSP/ ACO	MA	PQRS
Total Measures	~30	~50	~30
Patient/Caregiver Experience Measures/Complaints/Appeals	✓	✓	✓
Care Coordination/ Patient Safety	✓	✓	✓
Preventive Health	✓	✓	✓
At--□Risk Population/ Frail Elderly Health	✓	✓	✓
Customer Service		✓	
Financial Impact	**Up to 100% Payout**	**Up to 10% Total Revenue**	**Up to ~20% Reimb**

Quality Report Sample – PQRS to Region

PQRS Measure Number	Clinical Condition and PQRS Measure Specifications for PQRS clinical measures are posted at http://www.cms.gov/PQRS/Downloads/2010_PQRI_MeasuresList_111309.pdf http://www.cms.gov/PQRI/downloads/2010PQRIMeasuresGroupsSpecsManualandReleaseNotes_121809_2.zip	Physician PQRS Performance			
		YOU		Physicians in Iowa, Kansas, Missouri, and Nebraska Participating in PQRS	
		Number of Your Medicare Patients for Whom This Service Was Indicated	Percentage of Medicare Patients Who Received the Service	Number of Participating Physicians Reporting Cases for the Measure	Percentage of Medicare Patients Who Received the Service
Preventive Care and Screening					
110	Influenza Immunization for Patients ≥ 50 Years Old				
111	Pneumonia Vaccination for Patients ≥ 65 Years Old				
112	Screening Mammography for Women ≤ 69 Years Old				
113	Colorectal Cancer Screening for Patients 50 to 75 Years Old				

Source: 2010 Quality and Resource Use Report Medicare FFS – PQRS Value-based

How Will You Be Measured – Member Satisfaction

- Satisfaction measures & reports not yet standardized (except Medicare Advantage)
- Can expect same performance comparisons used for cost & quality to be included

Sample survey questions:
Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS), Agency for Healthcare Research and Quality
Q: In the last 12 months, when you phoned this doctor's office during regular office hours, how often did you get an answer to your medical question that same day?
A: 1. Never 2. Almost never 3. Sometimes 4. Usually 5. Almost always 6. Always
The complete survey and other CAHPS surveys are online (www.cchri.org/programs/programs_pas.html).

Patient Assessment Survey, Primary Care Physician survey instrument, California Cooperative Healthcare Reporting Initiative
Q: In the last 12 months, how often did this doctor seem informed and up-to-date about the care you got from specialist doctors?
A: 1. Never 2. Almost never 3. Sometimes 4. Usually 5. Almost always 6. Always 7. I did not see any specialist doctors in the last 12 months.
The complete survey and other PAS surveys are online (www.cchri.org/programs/programs_pas.html).

American Medical Group Assn. Patient Satisfaction Benchmarking Survey
Q: Would you recommend the physician/health care professional you saw to your family and friends?
A: 1. Definitely not. 2.Probably Not. 3. Probably Yes. 4. Definitely Yes.
The complete survey and more information about analyzing results are online (www.amga.org/research/psat/index_psat.asp).
Sources: Agency for Healthcare Research and Quality; California Cooperative Healthcare Reporting Initiative; American Medical Group Assn

Member Satisfaction/Experience Report Sample

Medicare.gov STAR ratings detail for beneficiaries

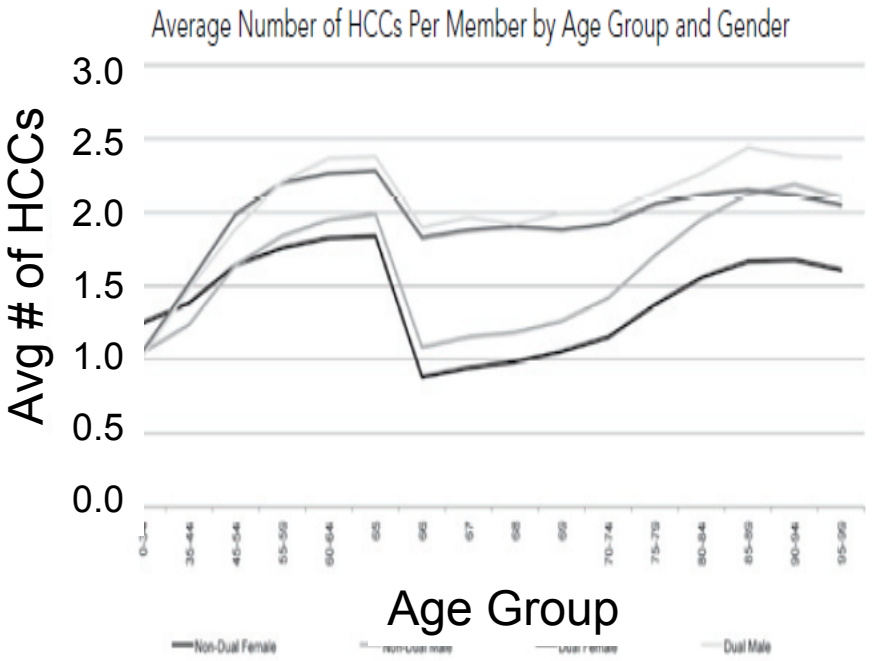
Overall Plan Rating [?]	
★★★★½ 4.5 out of 5 stars	**Humana Gold Plus H1036-146**
★★½ 2.5 out of 5 stars	**Universal Safeguard (HMO) (H5404-144)**
	Caution - This plan got **low ratings** from Medicare 3 years in a row
★★★★	★★★
Member Experience with Health Plan (?)	
Click to view data sources	
View how these plans compare to Original Medicare	
★★★ 3 out of 5 stars	★★★ 3 out of 5 stars
Ease of Getting Needed Care and Seeing Specialists (?)	
★★★★	★★
Getting Appointments and Care Quickly (?)	
★★★★	★★
Health Plan Provides Information or Help When Members Need It (?)	
★★	★★★★
Overall Rating of Health Care Quality (?)	
★★★★	★★★★
Members' Overall Rating of Health Plan (?)	
★★★★	★★★★
Coordination of Members' Health Care Services (?)	
★★	★★★

Source: medicare.gov Medicare Advantage Plan Compare

How Will You Be Measured – Risk Stratification

- Cost of Care benchmarks must be adjusted for health status of population
  - Medicare Advantage revenue adjusted for risk scores of members - HCC which is based on ALL combined coded conditions
  - MSSP – evaluates population and removes certain high cost expenditures
  - Many other variations based on product/payer
  - Traditional Medicare payment modifier will have risk component
- Exponential impact – benchmark determination and actual performance/reimbursement
- Regardless of methodology – complete spectrum provider diagnosis/coding is determining factor

HCC Survey Results
Coordinated Care Plan members (1)
Includes All 70 HCCs



(1) Excludes Chronic SNP, Institutional SNP, and PFFS Members and New Enrollee, Institutional, and ESRD members.

Source: Health Watch 2011

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How Will You Be Rewarded?

- At risk payers will be reimbursed according to your performance
- Imperative you negotiate contracts that align your reimbursement with performance not just volume
- Whether Medicare is payer or insurer is payer, incentives should be aligned
- Shared savings models are most common approach during transition
- FFS supplemented by performance incentives

Success Factors

- Organizing and engaging practice
- Integrating entire continuum of care
- Changing patient behavior & patterns of care
- Measuring & improving quality and satisfaction
- Creating advanced care delivery models

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Core Competencies for Providers in Outcome Based Reimbursement

Practice Competencies

- # Lives
- Geographic alignment & coverage
- Competitive price point
- Breadth of clinical services
- Care model flexibility
- Quality performance
- Quality/patient safety
- Utilization
- Satisfaction

Payer/Partner Competencies

- Aligned Products
- Market Receptivity
- Engaged Members (benefit design)
- Exclusivity / Narrower Networks
- Pricing Alignment
- Ability to Administer Approach
- Financial Capabilities
- Quality Measurement Tools

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Strategic Considerations

- *Accept the invitation* – strategic planning
- *Learn to dance* – implement data, reporting, and analytics interface tools
- *Look in the mirror* - generate performance reports
- *Primp* – identify and implement improvements
- *Work the room* - know your market, make sure market knows you
- *Fill your dance card* – maximize strategic alliances

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Strategic Alliances

- Vertical integration
  - Defined role in integrated delivery system
- Horizontal integration
  - Collaboration among independent providers

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Vertical Integration

- Situation
  - Employed by or affiliated with single integrated delivery system
- Challenge
  - Restricted patient (referral) base
- Response
  - Service line franchise

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Service Line Franchise

- Anticipate minimal changes to local market share
- Necessitates expansion into new markets
- Affiliate with local community hospitals to capture upstream referrals
- Develop continuum of care for specific patients
  - Condition management, e.g., diagnosis/treatment of certain cancers
  - Well-defined roles in patient management
  - Specialist as “extensivist”
- Benefits of care closest to home

Horizontal Integration

- Situation
  - Independent practice groups
- Challenge
  - Attract PCP referrals, gain access to networks
- Response
  - Clouding (clinical integration)

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Clouding

- Alliance of independent specialty practices
  - Centralize clinical activities (the “cloud”)
  - Maintain economic independence
- Branding based on enforced standards of quality and efficiency
- Clinical integration to overcome antitrust concerns
- Form follows function

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Clouding

- Centralize clinical activities
  - Common clinical protocols
    - Develop
    - Support implementation
    - Evaluate and refine
    - Enforce
  - Common performance measures
    - Data collection and analysis
    - Establish and enforce minimum standards

Clouding

- Maintain economic independence
  - Groups determine individual compensation
  - Keep incentives as close to the individual provider as possible
  - Furnish management/support services as deemed necessary and appropriate
  - Payer contracting?

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Multi-Specialty Group Practice Performance (MGMA 2011)

	Best Non-Hospital	Rest of Non-Hospital	Best Hospital/IDN	Rest of Hospital/IDN
Overhead %	58.3	60.0	56.8	83.4
Gross Charges per FTE MD	$1,372,247	$1,069,530	$995,303	$755,855
Physician wRVU per FTE MD	13,096	12,809	9,714	9,117
Total MD Net Revenue per FTE MD	$351,082	$280,439	$261,865	$69,881

Best of Luck and Thank You!

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APPENDIX

Additional sample reports for reference

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Cost Report Sample – Total per Capita Comparison of "Directed" Care

Exhibit 4. 2010 Total Per Capita Costs for Specific Services for the [#] Patients Whose Care You Directed

Service Category	Medicare Patients Whose Care You Directed			Average for Medicare Patients Whose Care Was Directed by [#] Physicians in Your Specialty in Iowa, Kansas, Missouri, & Nebraska			Amount by Which Your Medicare Patients' Per Capita Costs Were Higher (or Lower) than Average
	Your Medicare Patients Using Any Service in This Category		Total Risk-Adjusted Per Capita Costs	Medicare Patients Using Any Service in This Category		Total Risk-Adjusted Per Capita Costs	
	Number	Percentage		Number	Percentage		
All Services	#	100%	$XX,XXX	#	100%	$XX,XXX	($X,XXX)
Evaluation and Management Services in All Settings							
Provided by YOU for Your Patients	#	%	$XX,XXX	#	%	$XX,XXX	($X,XXX)
Provided by OTHER Physicians Treating Your Patients							
Procedures in All Settings							
Provided by YOU for Your Patients							
Provided by OTHER Physicians Treating Your Patients							
Inpatient and Outpatient Facility Services							
Inpatient Hospital Facility Services							
Outpatient and Emergency Services							
Clinic or Emergency Visits							
Procedures							
Laboratory and Other Tests							
Imaging Services							
Services in Ambulatory Settings							
All Ancillary Services							
Laboratory and Other Tests							
Imaging Services							
Durable Medical Equipment							
Post-Acute Care Services							
All Post-Acute Services							
Skilled Nursing Facility							
Psychiatric, Rehab, or Other Long-Term Facility							
Home Health							
Other Services							
All Other Services*							

Source: 2010 Quality and Resource Use Report Medicare FFS – PQRS Value-based

Quality Report Sample - Medicare

Clinical Condition and Measure Specifications for these clinical measures are posted at http://www.cms.gov/PhysicianFeedbackProgram/Downloads/claims_based_measures_with_descriptions_num_denom_excl.pdf	Physician Performance for All Medicare Patients			
	YOU		Physicians in Iowa, Kansas, Missouri, and Nebraska	
	Number of Medicare Patients for Whom This Service Was Indicated	Percentage of Medicare Patients Who Received the Service	Number of Physicians Included	Percentage of Medicare Patients Who Received the Service
Cancer				
Breast Cancer Surveillance for Women with a History of Breast Cancer				
PSA Monitoring for Men with Prostate Cancer				
Prevention				
Breast Cancer Screening for Women ≤ 69				

Source: 2010 Quality and Resource Use Report Medicare FFS – PQRS Value-based

Quality Report Sample – PQRS to Peers

Exhibit A. Your Performance on PQRS Quality Measures for Medicare Patients in All Organizations Through Which You Successfully Participated in 2010, by Tax Identification Number (TIN)

PQRS Measure Number	Clinical Condition and Measure	Total		Last Four Digits of TIN									
				[TIN #1]		[TIN #2]		[TIN #3]		[TIN #4]		[TIN #5]	
		Number of Your Medicare Patients for Whom This Service Was Indicated	Percentage of Patients Who Received the Service	Number of Your Medicare Patients for Whom This Service Was Indicated	Percentage of Patients Who Received the Service	Number of Your Medicare Patients for Whom This Service Was Indicated	Percentage of Patients Who Received the Service	Number of Your Medicare Patients for Whom This Service Was Indicated	Percentage of Patients Who Received the Service	Number of Your Medicare Patients for Whom This Service Was Indicated	Percentage of Patients Who Received the Service	Number of Your Medicare Patients for Whom This Service Was Indicated	Percentage of Patients Who Received the Service
Preventive Care and Screening													
110	Influenza Immunization for Patients ≥ 50 Years Old												
111	Pneumonia Vaccination for Patients ≥ 65 Years Old												
112	Screening Mammography for Women ≤ 69 Years Old												
113	Colorectal Cancer Screening for Patients 50–75 Years Old												

Source: 2010 Quality and Resource Use Report Medicare FFS – PQRS Value-based

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