Key clinical and financial concepts: The road to accountable care

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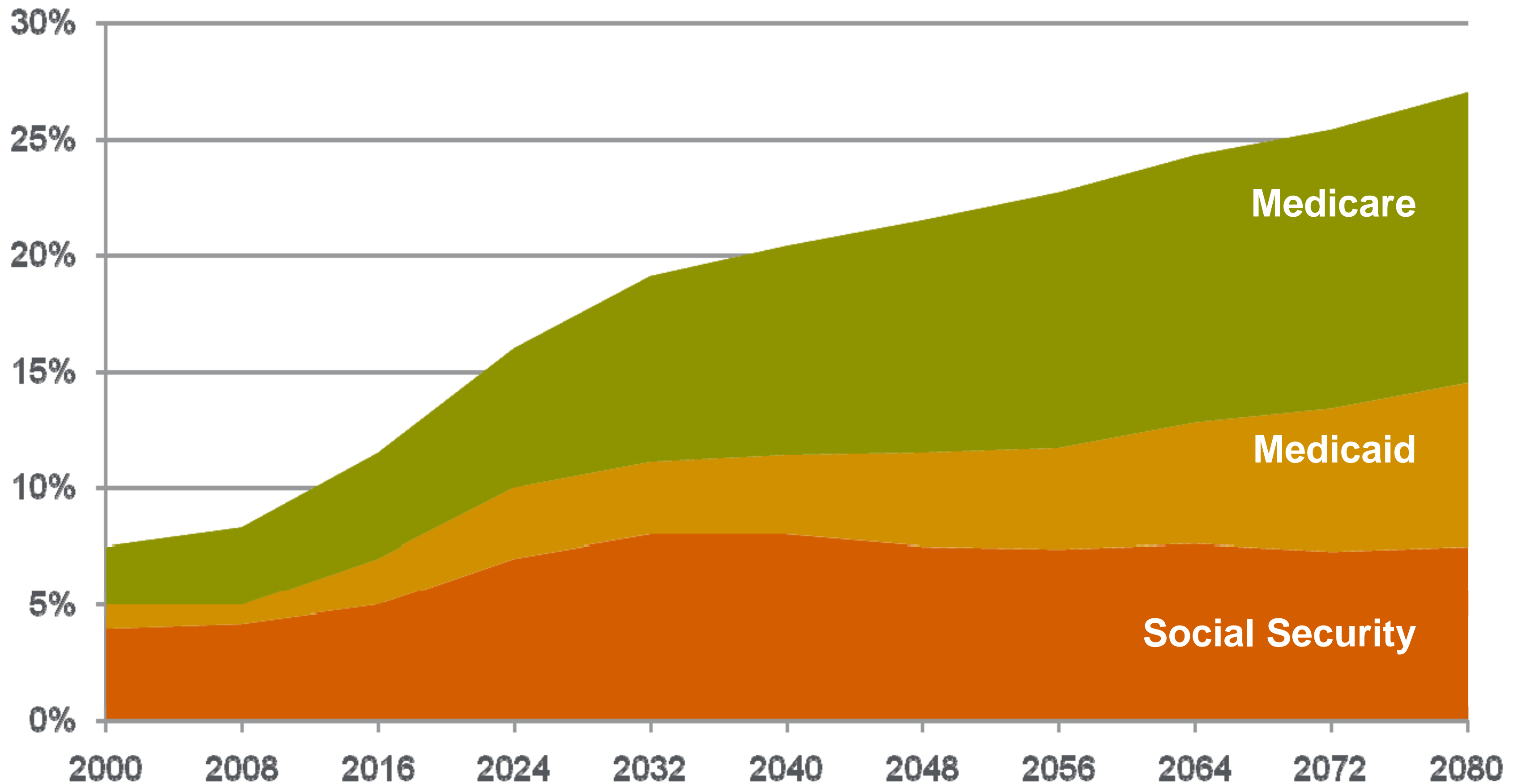
Optum

The context for the ACO discussion re: IPA's



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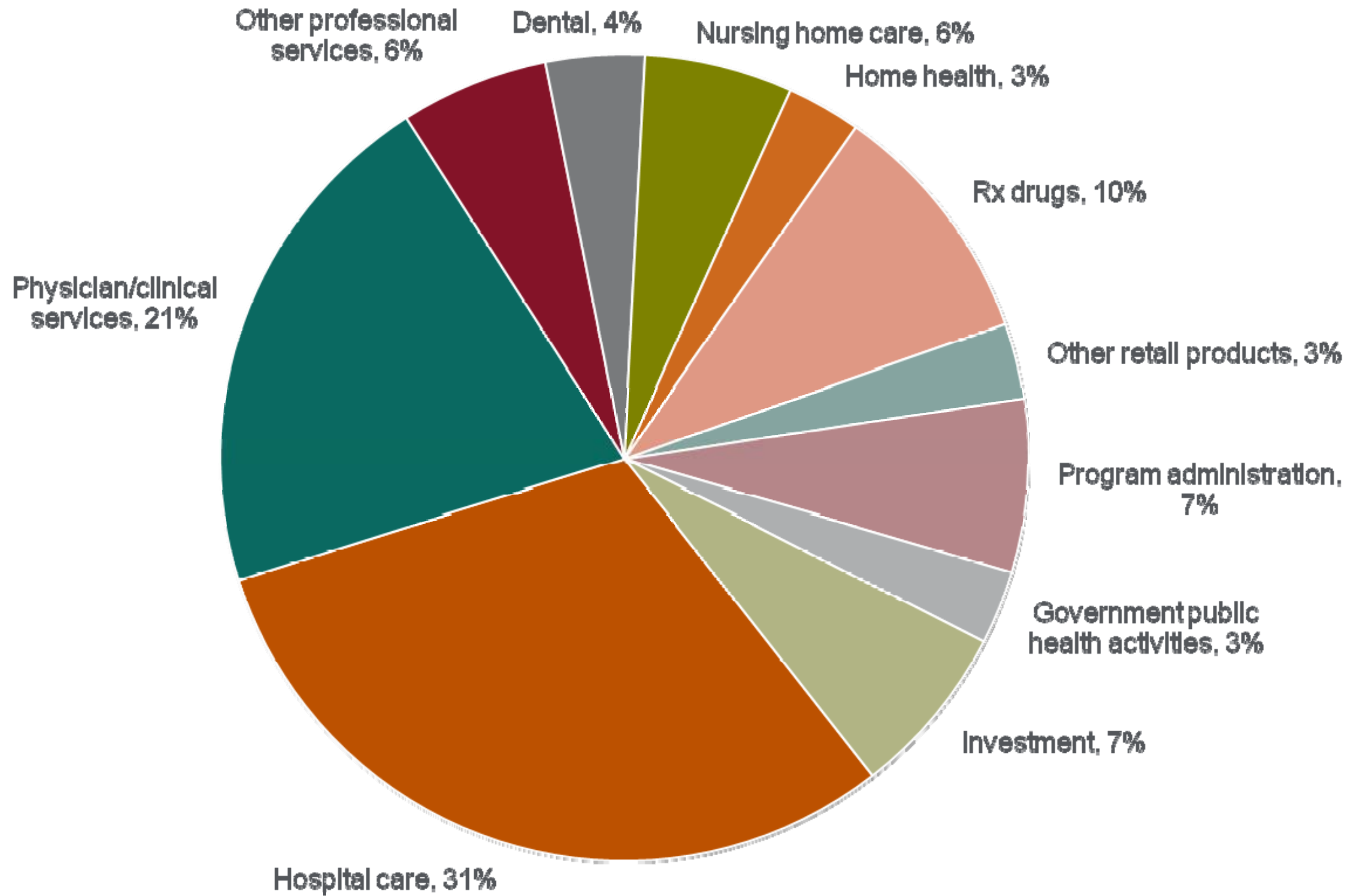
Where do we spend the money?



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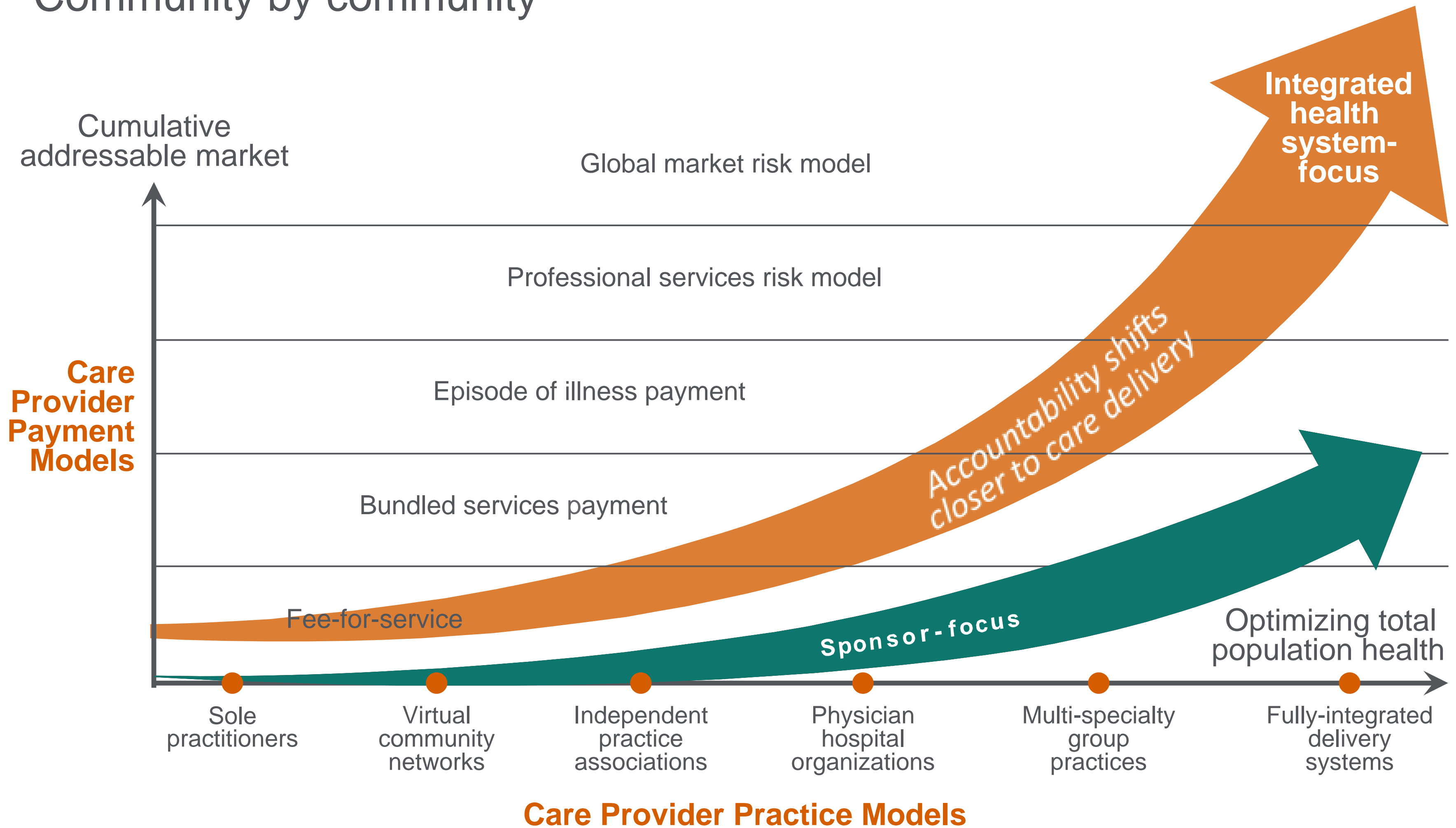
Market change will take many forms…

Community by community



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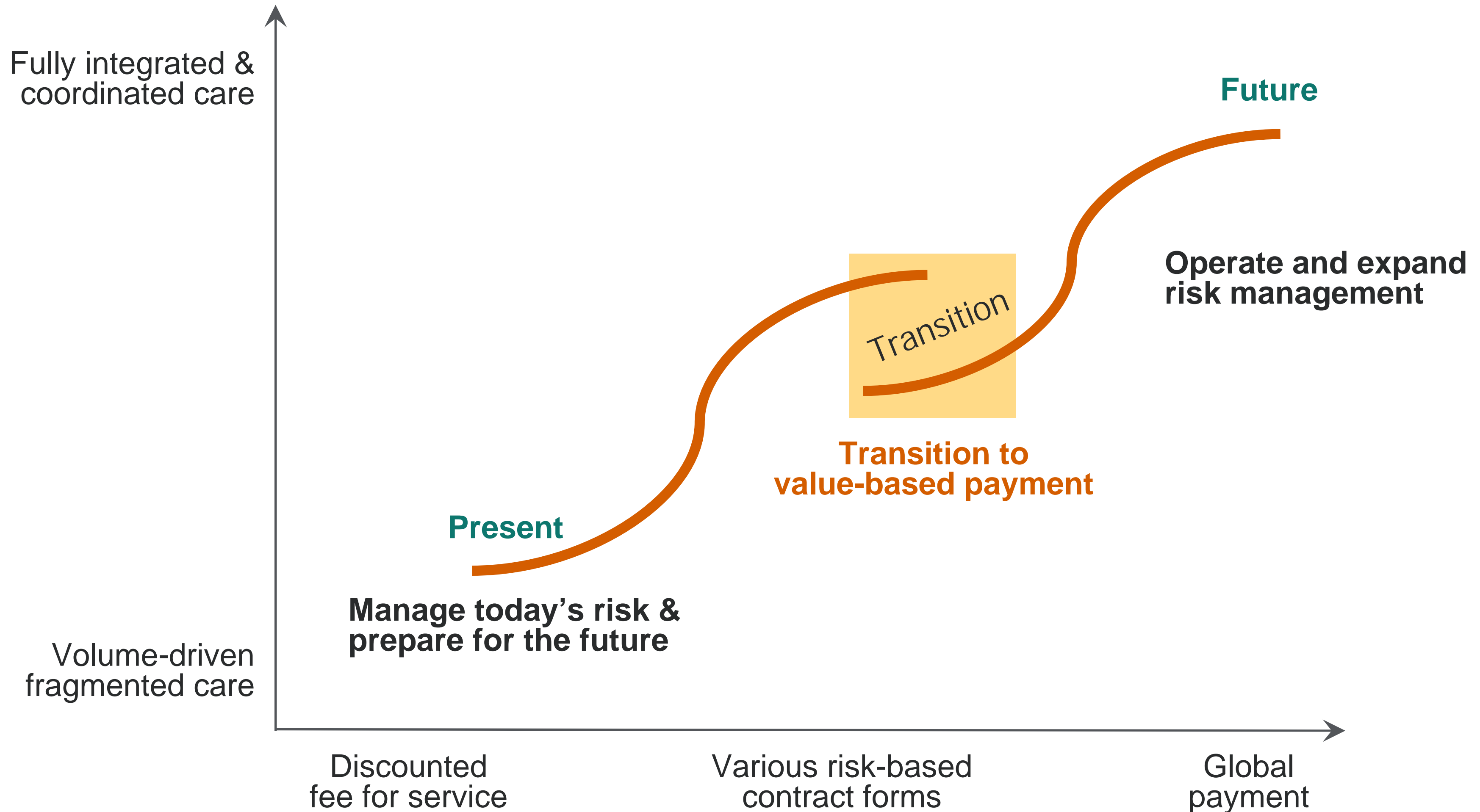
The “gap” in migration to value-based payment



Delivering on the promises of connected, intelligent, aligned communities

Design	Build	Operate

Design

Accountable Care Assessment

- Organizational Readiness
- Financial Feasibility
- Network Viability

Governance & Organizational Alignment

- Strategy and Governance
- ACO Structure
- Organizational Alignment and Planning

Actuarial and Financial Modeling

- Population Cost Modeling
- Physician Compensation
- Payer Contract Model and Validation

Build / Operate

Analytics and Performance Reporting

- Performance monitoring (cost, quality, outcomes, satisfaction)
- Assessing Population Risk
- Evidence based guidelines
- Care Coordination

Connectivity & Provider/Consumer Communication

- Integration of Administrative and Clinical systems and existing HIEs
- Web Portal (physician and patient) support

Care Management Support

- Care Coordination Support Services
  - Patient Centric Services ranging from Referral Management to End of Life
- Patient Engagement Services

Network Management & Operations

- Network Performance Management Services
- Out-of-Area Network Augmentation
- TPA Services
- Fee for Service Revenue Cycle Solutions

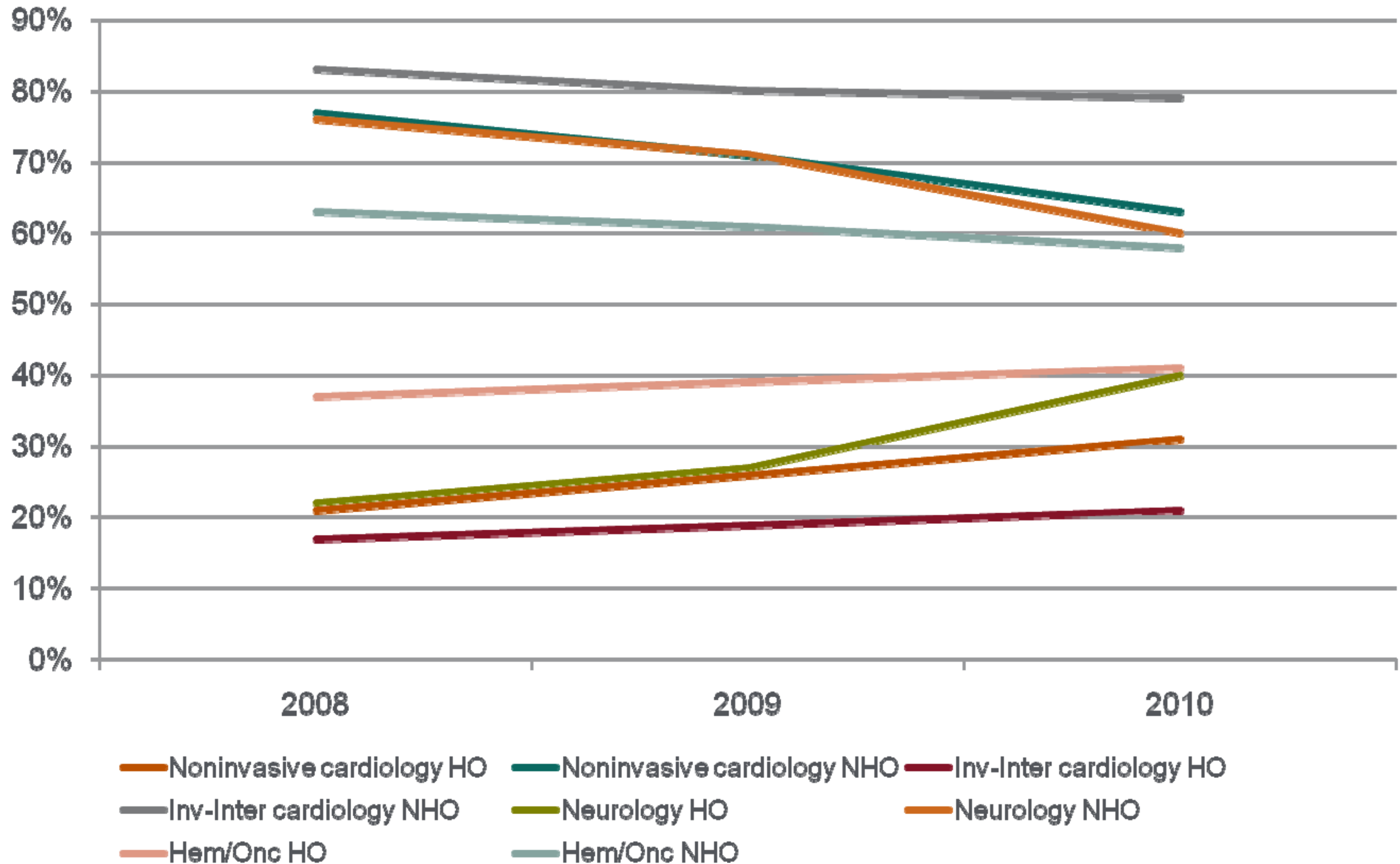
Provider Sponsored Health Plan Support

- TPA services
- Stop Loss Insurance
- Insurance Licensure
- Member Marketing Services
- Member Servicing & Billing

Payer Alignment

- Payer alignment with Health System Population Health Risk Capabilities
- Performance monitoring across a predefined set of metrics
- Case studies demonstrating Health System ability to manage Population Health Risk

Ownership of physicians creates focus on clinical integration



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“Generally the approach to clinical integration must constitute a credible strategy and operational capability resulting in clinical efficiency and improved outcomes across the contracting organization, not an attempt to gain leverage through contracting at scale.”

Clinical integration: A review

- Sherman act: Anti-trust
- 1982: Arizona v. Maricopa County Medical Society
  - "maximum fee schedule" for a broad area, creating a price fixing problem
- 1988: Hassan v. IPA – Established the concept of a "legitimate" joint venture
  - Not for the broad purpose of fixing pricing
  - Legitimate joint venture based on an attempt at clinical efficiencies and cost reduction
  - In this case physicians in the IPA shared both upside and downside risk
- Other factors
  - Stark
  - CMP
  - Anti-Kickback
  - Corporate Practice of Medicine/State regulation
  - Etc.

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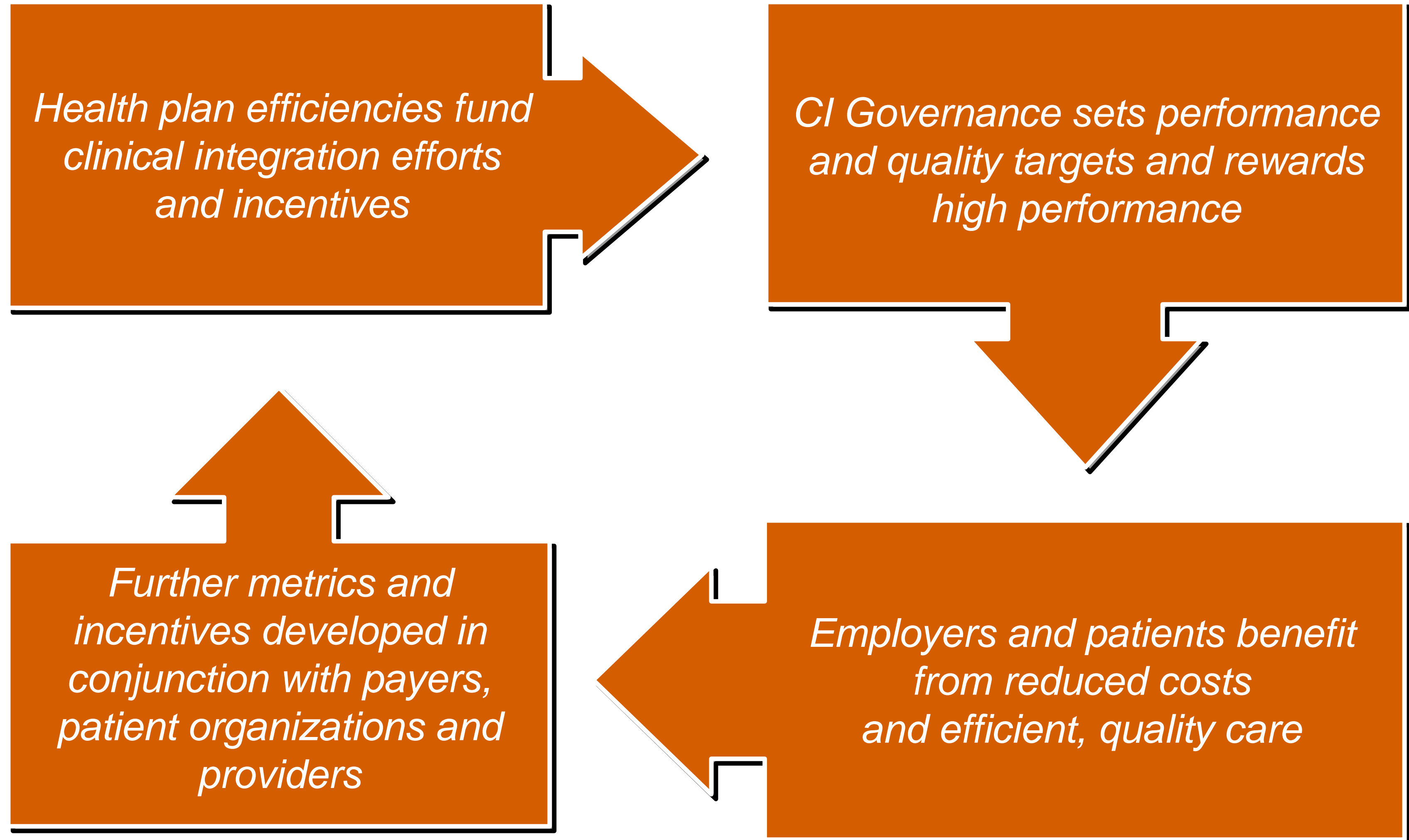
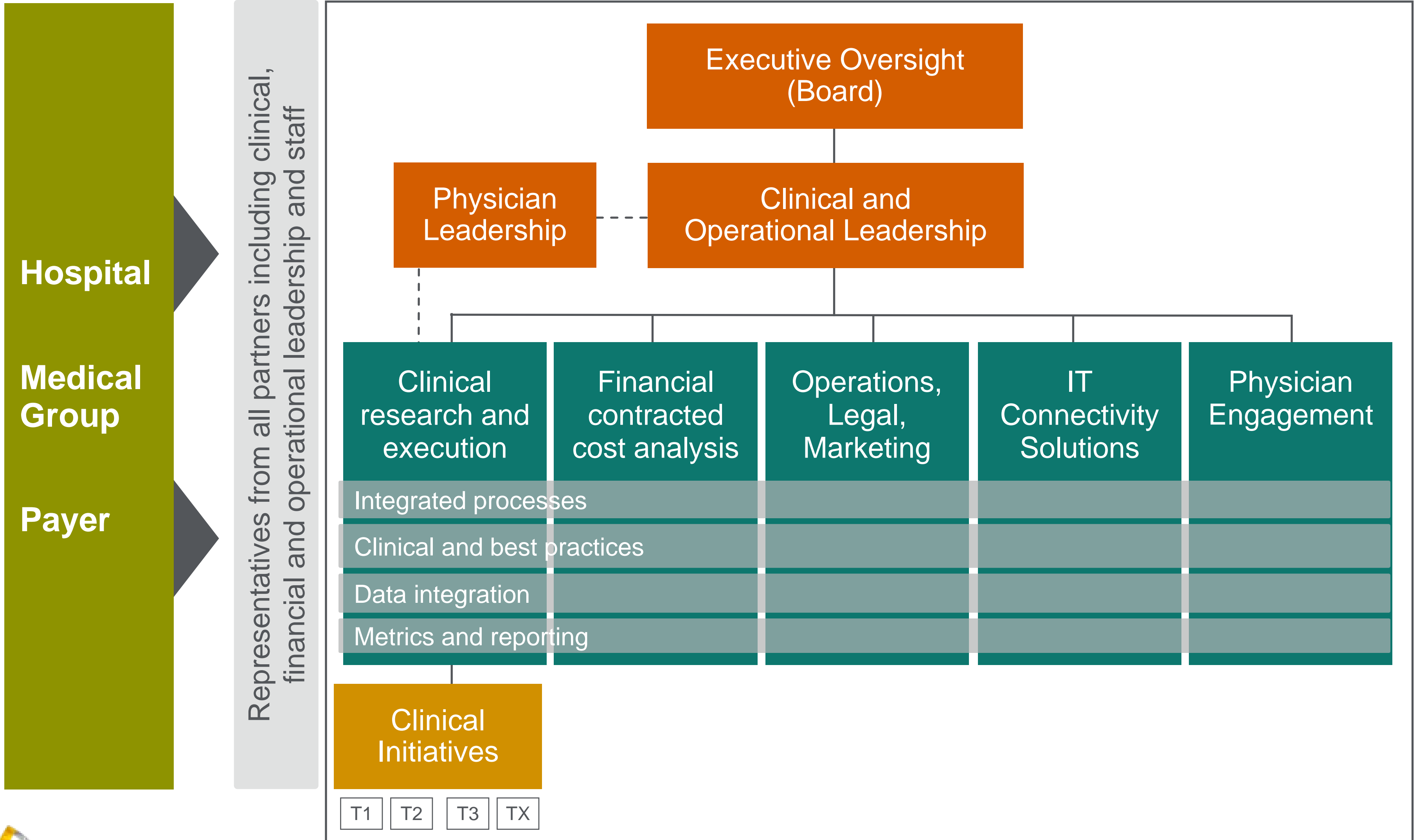
Clinical integration: A valid business cycle



Governance and leadership



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Questions for testing clinical integration

- What do the physicians plan to do together from a clinical standpoint?
  - What specific activities will (and should) be undertaken?
  - How does this differ from what each physician already does individually?
  - What ends are these collective activities designed to achieve?
- How do the physicians expect to accomplish these goals?
  - What infrastructure and investment is needed?
  - What specific mechanisms will be put in place to make the program work?
  - What specific measures will there be to determine whether the program is working?
- What basis is there to think that the individual physicians will actually attempt to accomplish these goals?
  - How are individual incentives being changed and realigned?
  - What specific mechanisms will be used to change and realign the individual incentives?

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Questions for testing clinical integration

- What results can reasonably be expected from undertaking these goals?
  - Is there any evidence to support these expectations, in terms of empirical support from the literature of actual experience?
  - To what extent is the potential for success related to the group's size and range of specialties?

- What does joint contracting with payers contribute to accomplishing the program's clinical goals?
  - Is joint pricing reasonably necessary to accomplish the goals?
  - In what ways?

- To accomplish the group's goals, is it necessarily (or desirable) for physicians to affiliate exclusively with one entity or can they effectively participate in multiple entities and continue to contract outside the group?

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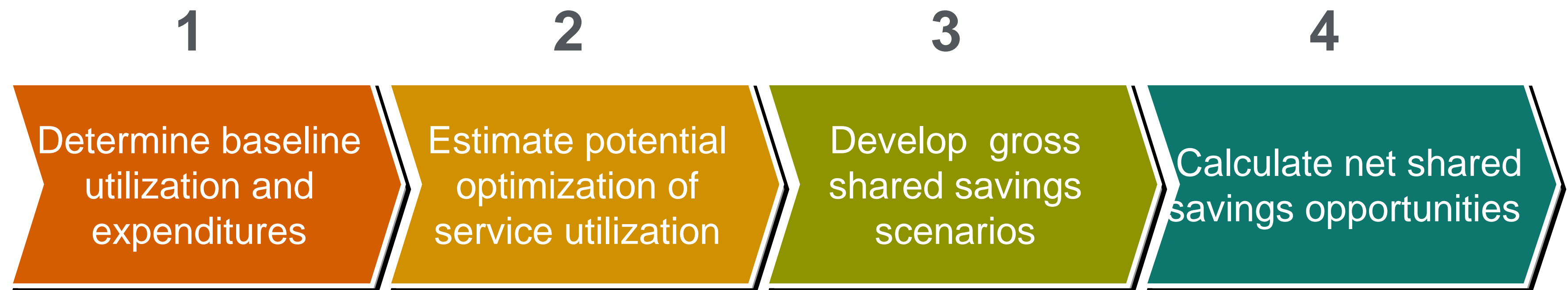
Financial implications of Accountable Care

Contract to the opportunity: The financial analysis process

Four Step Process:



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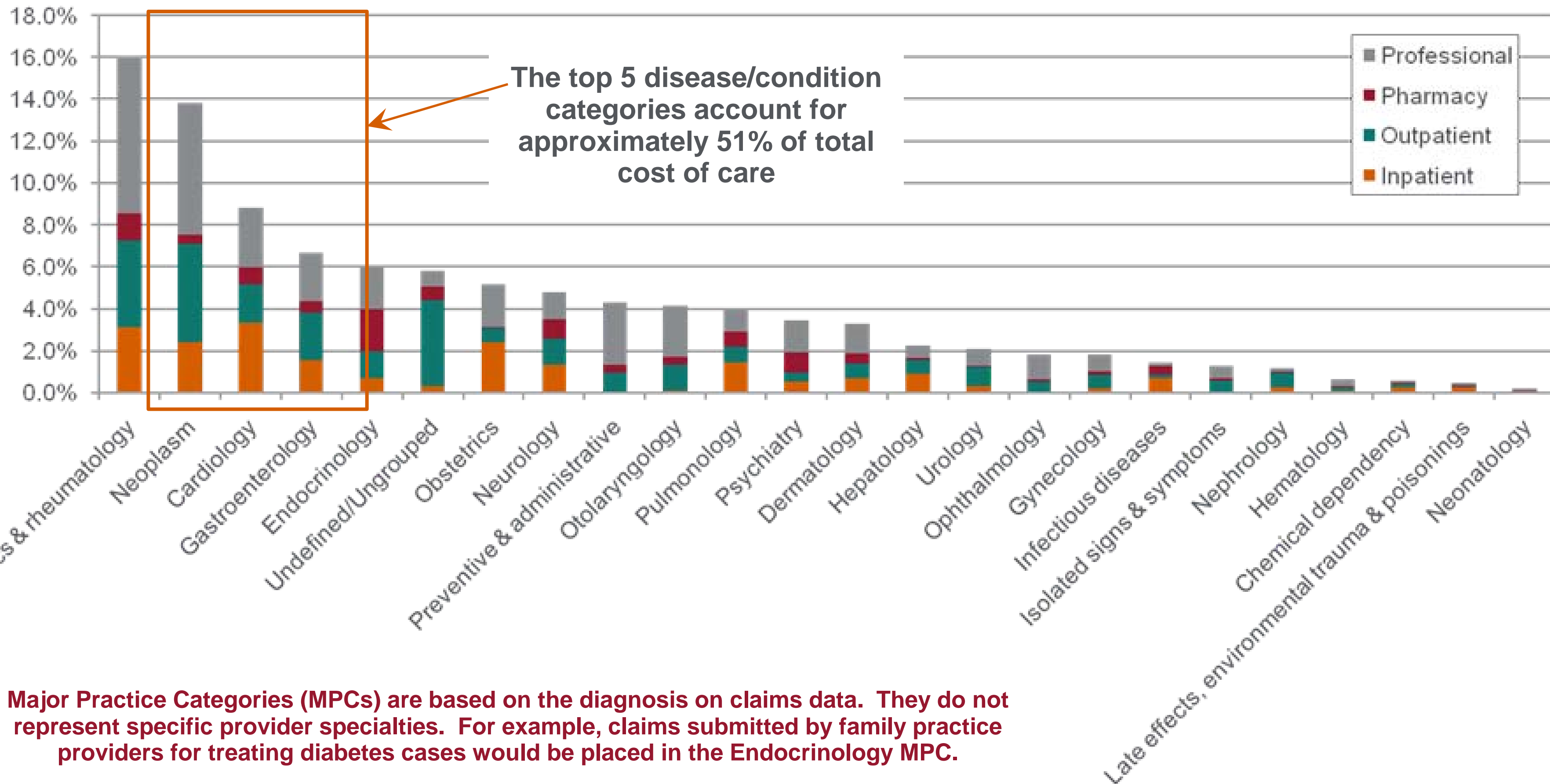
Demographics and population cost distribution by major practice category



Major Practice Categories (MPCs) are based on the diagnosis on claims data. They do not represent specific provider specialties. For example, claims submitted by family practice providers for treating diabetes cases would be placed in the Endocrinology MPC.

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Understanding your community vs. your census: Atlanta, GA

Health Status

Average Life Expectancy	
Atlanta, GA	**75.5**
National Avg	**76.6**
1 Std Dev Range	**75 – 78.3**
National Max	**80.3**
National Min	**71.2**
Ranking (out of 306)	**75**

Obesity	
Atlanta, GA	**22.0%**
National Avg	**23.2%**
1 Std Dev Range	**20.2 – 26.1%**
National Max	**31.4%**
National Min	**15.3%**
Ranking (out of 306)	**204**

Smoking	
Atlanta, GA	**20.0%**
National Avg	**22.0%**
1 Std Dev Range	**18.4 – 25.7%**
National Max	**31.9%**
National Min	**7.2%**
Ranking (out of 306)	**224**

Diabetes	
Atlanta, GA	**6.4%**
National Avg	**7.3%**
1 Std Dev Range	**5.9 – 8.7%**
National Max	**10.9%**
National Min	**3.5%**
Ranking (out of 306)	**230**

Triple Aim Status

Maximum composite ranking is 9, minimum ranking is 1. A higher composite ranking represents more opportunity for improvement

Quality	Composite Ranking	Most Unfavorable Measure
Atlanta, GA	**2.6**	Knee Replacements per 1k Medicare Enrollees **7.0**
National Avg	**3.7**	**8.8**
1 Std Dev Range	**2.6 – 4.8**	**6.9 - 10.7**
National Max	**7.2**	**14.6**
National Min	**1.6**	**3.5**
Ranking (out of 306)	**247**	**253**

Cost	Composite Ranking	Most Unfavorable Measure
Atlanta, GA	3.7	Mammography Screening 61%
National Avg	3.6	63%
1 Std Dev Range	2.4 - 4.7	57.5% – 68.8%
National Max	7.3	76%
National Min	1.6	49%
Ranking (out of 306)	101	111

Satisfaction	Composite Ranking	Most Unfavorable Measure
Atlanta, GA	**3.0**	Average Life Expectancy **75.5**
National Avg	**3.6**	**76.6**
1 Std Dev Range	**2.0 - 5.3**	**75 - 78.3**
National Max	**8.7**	**80.3**
National Min	**1.2**	**71.2**
Ranking (out of 306)	**122**	**75**

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Community snapshot: Atlanta, GA

Total Population Demographics	
Total Population	5.8M
Uninsured Estimate*	1.2M
Medicare Advantage Members	26k
Medicare FFS Member Estimate*	446k
Medicaid Member Estimate*	833k
# of Fortune 1000 Employers	27

Physician Demographics	Atlanta, GA	Nat Avg
# of PCP per 100K Residents	64.2	70.5
Specialists per 100K Residents	118.4	120.1
Surgeons per 100K Residents	39.8	41.2

Largest IDNs

System 1 (22%)		
# of Hospitals	Gross Patient Revenue	Est 2013 Medicare Penalty
20	$7.04M	$0

System 2 (12%)		
# of Hospitals	Gross Patient Revenue	Est 2013 Medicare Penalty
5	$3.7M	$0.5M

Largest Hospitals

Hospital A (6%)	
Gross Patient Revenue	Est 2013 Medicare Penalty
$1.9M	$0

Hospital B (6%)	
Gross Patient Revenue	Est 2013 Medicare Penalty
$1.8M	$0

Readmission Rate

Heart Failure	
Atlanta, GA	**19.3%**
National Avg	**18.6%**
1 Std Dev Range	**14.4 – 22.7%**
National Max	**27.3%**
National Min	**6.9%**
Ranking (out of 306)	**135**

Heart Failure	
Atlanta, GA	**14.3%**
National Avg	**14.3%**
1 Std Dev Range	**11.2 – 17.3%**
National Max	**20.3%**
National Min	**5.2%**
Ranking (out of 306)	**161**

Heart Failure	
Atlanta, GA	**10.5%**
National Avg	**9.8%**
1 Std Dev Range	**5.4 – 14.2%**
National Max	**21.3%**
National Min	**1.7%**
Ranking (out of 306)	**120**

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Important data: Medical variability, cost variability and health status

Medical Variability

- Knee replacement per 1K Medicare enrollees (2005)[1]
- Hip replacement per 1K Medicare enrollees (2005)[1]
- Back Surgery per 1K Medicare Enrollees (2005)[1]
- Diabetes Discharges per 1K Medicare Enrollees (2005)[1]
- COPD Discharges per 1K Medicare enrollees (2005)[1]
- UHn physician quality score (compared to 1.0 national average)[1]

Cost Variability

- Acute care hospital beds per 1K residents[1]
- Total specialists per 100K residents[1]
- Medicare spending per decedent by site of care during the last two years of life[1]
- Medicare hospital days per decedent during the last two years of life[1]
- Medicare physician visits per decedent during the last two years of life[1]
- Back pain cost per incident[2]
- Cardiac cath cost per incident[2]
- Hypertension cost per incident[2]
- Diabetes screening % HbA1c[3]
- Mammography screening[3]
- Medicare readmission data[5]

Health Status

- Average life expectancy[4]
- Obesity percent[4]
- Smoking percent[4]
- Diabetes percent[4]
- Poor physical health days per month[3]
- Poor mental health days per month[3]
- Low birth rate (<2,500 grams)[3]
- Sexually transmitted diseases per 100k residents[3]

1: Information provided by Dartmouth Atlas
2: Information provided by Ingenix - Actuarial Group
3: Information provided by Wisconsin Population Health Institute
4: Information provided by HHS Community Health Sts
5: Medicare hospital compare

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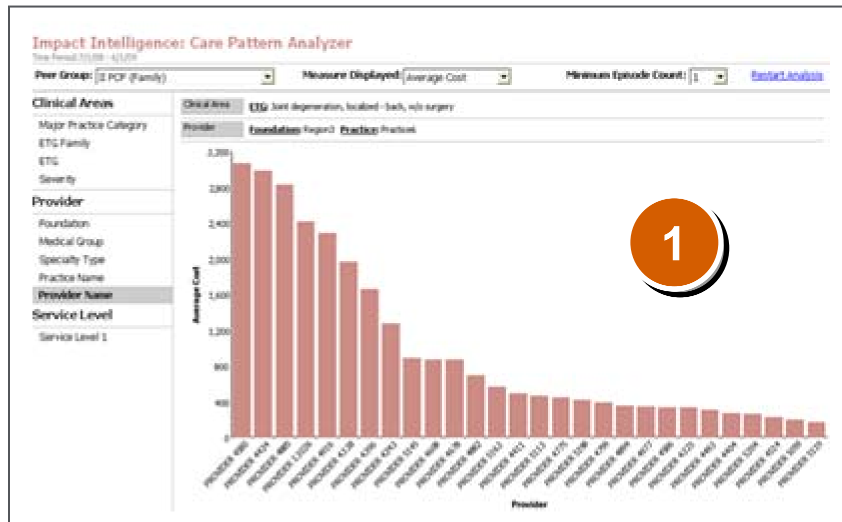
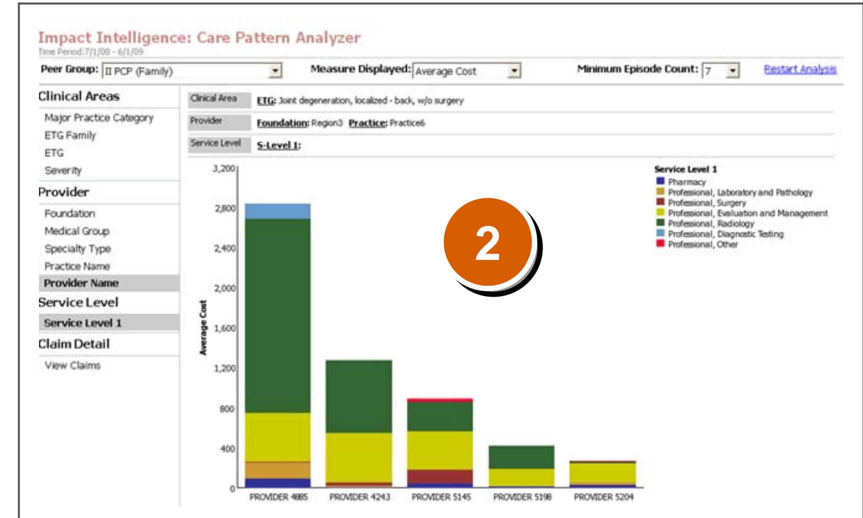
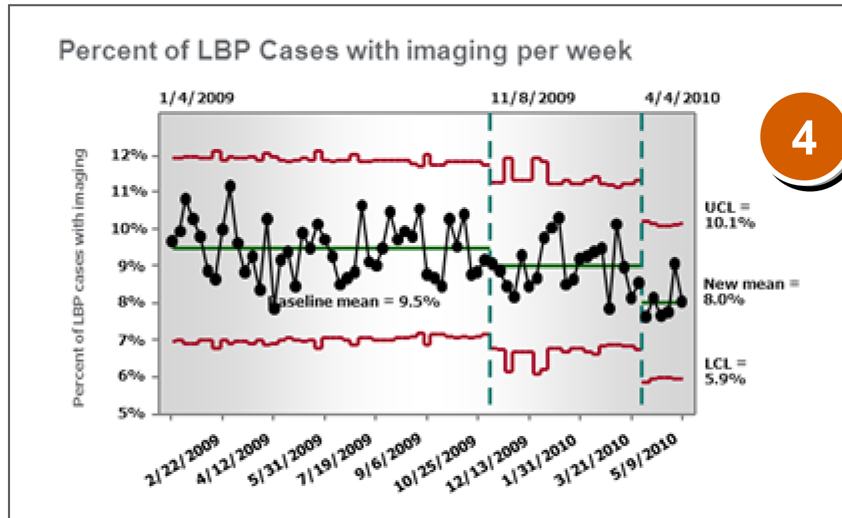
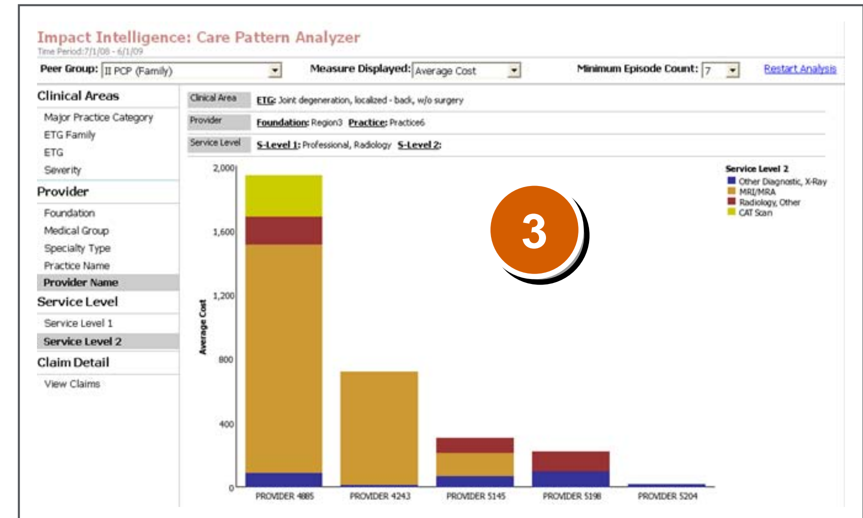
Understanding your performance: Back pain









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Care demand vs. Proactive care: Chronic disease registries

Family Health Plan

INGENIX. IMPACT® Pro

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SEARCH Members By Member ID | Enter Search Value

Back to Reports

Diabetes, Level 4 (High)

Filter Members | Columns

Total Rows: 157

Filter: Current report shows members who have Primary Risk Category = Diabetes and Future Risk, Costs equal or greater than 1.84 (Top 20%).
The report includes only members who have any of the following Clinical Indicators: "Diabetes - ER, 2 or more Visits", "Diabetes - Inpatient, 1 or more Admits", "Diabetes - Type I", "Diabetes - Uncontrolled".
Members who have any of the following Clinical Indicators: "**Renal Failure**" were excluded from the current report.
The report includes only members who have any of the following Care Opportunities: "**Diabetes**".

Page: 1 of 1

Member ID	Age	Sex					Future Risk, Costs	Future Risk, Costs, 3 Months	Future Costs	Inpatient Stay Probability	Prior Total Costs (Annualized)
0000965976	62	Female	✓	✓			12.78	13.55	$37,880	24.9 %	$46,762
2410791005	44	Female	✓	✓	✓		11.28	17.49	$33,430	65.1 %	$72,704
0003554203	75	Female	✓	✓			11.14	10.40	$33,030	48.3 %	$28,430
0672078580	62	Female	✓	✓			10.19	11.05	$30,190	19.3 %	$5,653
1570576220	72	Male	✓	✓	✓		9.74	10.01	$28,880	36.9 %	$67,395
0000552527	67	Female	✓	✓			9.66	9.37	$28,630	36.2 %	$16,744
1505539446	66	Female	✓	✓			9.20	8.08	$27,280	38.2 %	$23,288
0003933277	62	Male	✓	✓			9.13	8.56	$27,070	54.6 %	$13,065
1385250423	47	Female	✓	✓			9.04	10.06	$26,780	33.7 %	$11,477
0410473445	57	Male	✓	✓			8.95	7.92	$26,540	42.4 %	$75,093

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Healthcare Reform: Coming into focus in 2012

The New Healthcare Reform Act: Key Concepts

- Expand Coverage
  - Large Medicaid Expansion
  - Exchanges to bring private insurance to more patients, backed by subsidies
- Shared Responsibility to Increase Coverage
  - Individual Mandate (Subject to Supreme Court)
  - Employer Incentives/Fines
- Insurance Regulation
- Payment Reform
  - Incentives for Primary Care and Workforce Change
  - Focus on Wellness and Preventative Care
- Cost Containment & Reform Financing Measures

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Expansion of Coverage

- By some estimates 28-32 million entering the ranks of the insured
- State insurance exchanges
  - Will they drive decreased price competitively?
- Subsidies for consumers purchasing through exchanges
  - Eligible to a higher than usual income level
- Large Medicaid expansion (higher incomes now qualify for coverage)

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Sharing the Cost Burden

- Individual Mandate in review
- Fines for employers not offering coverage
  - Enough to keep coverage going?
- Tax breaks for small businesses offering coverage

* If not ruled unconstitutional by Supreme Court

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Private Payer Reform

- 85% Medical Loss Ratio beginning in 1014
- No hard dollar caps
- Can't drop patients!
- 2013 – All new plans have to cover pre-existing conditions
- Exchanges – Minimum Benefits Regulations – 2014

How about government payers?

- Primary Care – 10% Bonus
- Incentives for practicing general surgery in rural areas
- Increased funding for Behavioral Health
- PCP's get Medicare rates on Medicaid services in 2013-14

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Where do these docs come from?

- Student loan incentives for primary care
- National Health Service Corps – Primary Care Support
- Community Health Centers – Expanded Funding
- Redistribution of residency slots to Primary Care and General Surgery

- Interestingly – Behavioral Health absent here

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How to pay for it?

- Cost containment and quality
  - Pilot programs for Medical Home, Bundled Payment, and Accountable Care Organizations (ACOs)
  - Reduces hospital payments for Preventable Readmissions & Infections
  - Payment Advisory Board (IPAB) to make recommendations to Medicare.
  - Center for Innovation – test new payment/delivery systems
- New dollars coming in…
  - Increased taxes to high wage earners
  - Fees to insurers and pharmaceutical companies
  - Likely more to come here…

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Cost Estimates (CBO)

- 938 billion over 10 years
- Deficit Reductions
  - $140 Billion-10 Years
  - $1.2 Trillion years 10-20
- Unlikely to change costs in the current private marketplace
- Price may decrease for exchange customers – cost is a different calculation, but may decrease

Elmendorf, D. (2010, March 18) Preliminary Cost Estimate for Pending Health Care Legislation. Retrieved 5 April 2010 from Congressional Budget Office Website: http://cboblog.cbo.gov/?p=508

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We live in interesting times!

- “Back to the Future” But with some significant changes
  – Better analytics
  – Better infrastructure and data collection
  – Better penetration of EMR’s
  – Cold, Hard Financial constraints
- Change in Clinical Practice is the expectation
  – Care coordination must get done
  – Keeping patients out of the hospital is the major cost containment
  – Variability in clinical practice faces inspection
- Respect for the clinician is a key feature of new models
- Successful Models are out there, getting traction and getting contracts

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Questions?

For additional Information:
Optum and Harris Interactive conducted a national survey of physicians, hospitals, and U.S. adults that clearly points to seven major opportunities for making the American health care system work better for everyone.

To download the full report, use your mobile device to scan this QR code.

You may also pick up a hard copy at the Optum booth in the Exhibit Hall or visit **http://institute.optum.com**