Accountable Care Organizations: The IPA Model
Hill Physicians Medical Group: Lessons from 25 Years in the Trenches

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Context for Organizing Hill in 1984

- Emphasize primary care, population management, coordinate care
- Create accountability for costs and quality
- Develop regional medical delivery system to compete with Kaiser
- Create balanced table between payers, hospitals, and physicians (PriMed/MSO)

**Challenge:** Getting independent physicians to forgo individual prerogatives in favor of a strong organization aimed at the greater good.

**Acid test:** Is the long-term result better for their patients and ultimately better for themselves?
25 Years Later

The good:

- 3,100 physicians/1,600 practice locations/35 hospitals
- 320,000 HMO members/over 2M total patients
- 100% capitated: commercial, MediCare, Medi-Cal
- Serving 9 Northern California counties
- Consistently among top-performing medical groups
- High physician satisfaction (90%)
Physician Satisfaction at Hill Physicians

Measured annually by independent survey group

66% 76% 80% 83% 88% 90% 92%

2000 2001 2002 2003 2004 2005 2006
25 Years Later (continued)

The bad:
- Commercial HMO enrollment is falling
- Failure to engage and integrate hospitals into ‘system’
- 90% of PCPs in small 1-2 person practices

The ugly:
- Medical premiums have risen 131% since 1999
- Primary care is heading for a crisis
- Fundamentals haven’t changed
**PriMed: The Engine Under Hill’s Hood**

- Exclusive manager since inception
- Cost-based budget plus performance incentives
- Annual goals/objectives

*Management Services Organization*
Key Clinical/Practice Initiatives

**Clinical**
- Predictive Modeling
- Group Appointments
- Polypharmacy Program
- Neurobehavioral Pain
- ‘Clinical Snap-shots’

**Practice Programs**
- ‘Finding Balance’
- Practice Support
- Leadership Training
- Financial Assistance
- Point of service surveys
Hill’s Internal P4P

- Developed in 1997 for PCPs; some specialists added in 2004
- Rewards efficient and progressive practices
- Performance based, population based
- Paid in addition to fee-for-service payments
- Qtrly. distribution/ave. $25K per M.D./25% of compensation
- Continuously evolving
Pay for Performance

$ Millions

Years: 2002 to 2009

- **Health Plan Bonus Payments to Hill**
- **Hill Incentive Payments to its Physicians**

Specific Payments:
- 2002: $3.8, $7.5
- 2003: $5.2, $13.5
- 2004: $4.8, $17.5
- 2005: $5.0, $26.0
- 2006: $5.1, $32.2
- 2007: $4.3, $33.8
- 2008: $4.0, $27.4
- 2009: $3.8, $32.0
Leveraging Technology – Key Steps

- Web access to administrative data for practices
- RelayHealth: secure messaging for providers and patients
- Ascender: online pay for performance tool
- EHR software licensing, installation & support on “enterprise-wide” basis (ASP model)
- Interface engine to build EHR data exchanges
- Develop necessary clinical data exchange arrangements (interfaces/HIE)
- Build relationships for future HIE collaboration
- Emphasize an all provider/all patient approach
ACOs: Issues/Challenges

1. Physicians vs. Management: A Natural Conflict?

**Physicians:** autonomous with a high degree of individual control.

**Management:** getting people together to accomplish desired goals; includes planning, organizing, staffing, leading/directing and controlling.

**Physicians:** focused on the individual patient

**Management:** emphasis on the broader market population

**Physicians:** trained to avoid risk, make no mistakes

**Management:** taking risk is part of business equation: if you are not making mistakes, you are not cutting edge.
2. Strong ‘physician’ leadership is helpful but leadership can come from pharmacists, nurses and, good heavens, even ‘lay’ management.

3. Building Trust with Physicians:
   - purpose and goals that resonate
   - transparency; full and open communication
   - accountability; checks and balances
   - align incentives over time
   - execute: do what you say you’re going to do, and do it right
Issues/Challenges (continued)

4. Conflict: unavoidable; the key is constantly clarifying common purpose and work through the conflict.

5. The ‘Illusion of Technique’: health care chases one fad after another, mostly tactics and techniques parading as systemic change: P4P and the “medical home” are latest examples.

6. ACOs don’t lower costs absent market incentive—currently no market incentive in California for existing ACOs to lower their costs; in fact, opposite condition prevails.

7. Integrated medical groups are higher performing but don’t travel well; IPAs are replicable and at a much lower cost.
8. Size matters: 5,000 patients is way too low, more like 50,000 (or more)
   - economies of scale
   - management talent
   - capital development
   - market influence
   - spreading risk

9. Capitation is the octane that drives the engine:
   - shared risk bonuses alone are insufficient to counter FFS incentives
   - claims data is necessary for performance improvement/oversight

10. Global capitation sooner rather than later
    - create integration, breakdown silos
    - rationalize, redirect funding
CalPERS Initiative

- Hill Physicians – CHW (hospital) – Blue Shield (health plan)
- Linking the players, aligning incentives
- Competing directly with Kaiser
- Bending the price trend
- Multi-year pilot