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# Accountable Care Organizations: The IPA Model

## Hill Physicians Medical Group: Lessons from 25 Years in the Trenches

### The Fifth National Pay for Performance Summit

**March 10, 2010**

**Steve McDermott, CEO**

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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?

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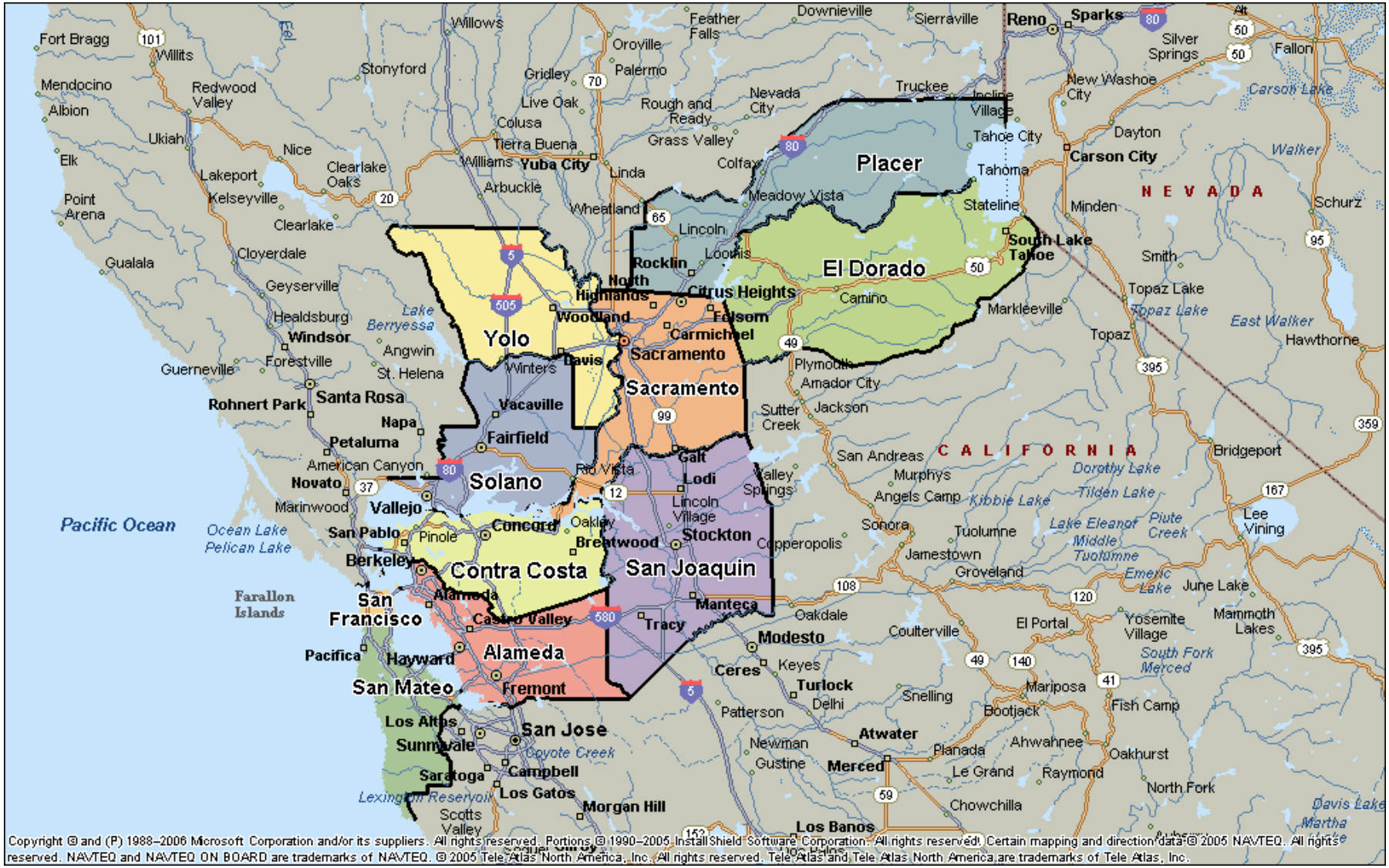
# 25 Years Later

The good:

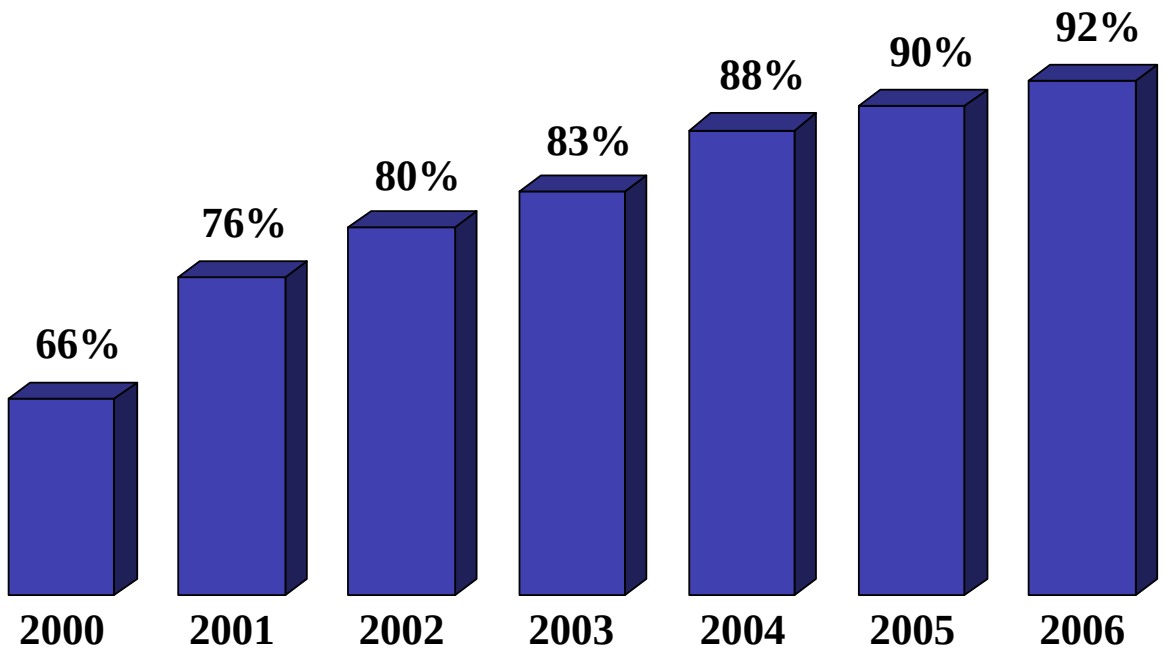
- 3,100 physicians/1,600 practice locations/35 hospitals
- 320,000 HMO members/over 2M total patients
- 100% capitated: commercial, MediCare, Medi-Cal
- Serving 9 Northern California counties
- Consistently among top-performing medical groups
- High physician satisfaction (90%)

# Hill Physicians' Market - 9 Counties



# Physician Satisfaction at Hill Physicians

**Measured annually by independent survey group**



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# 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'

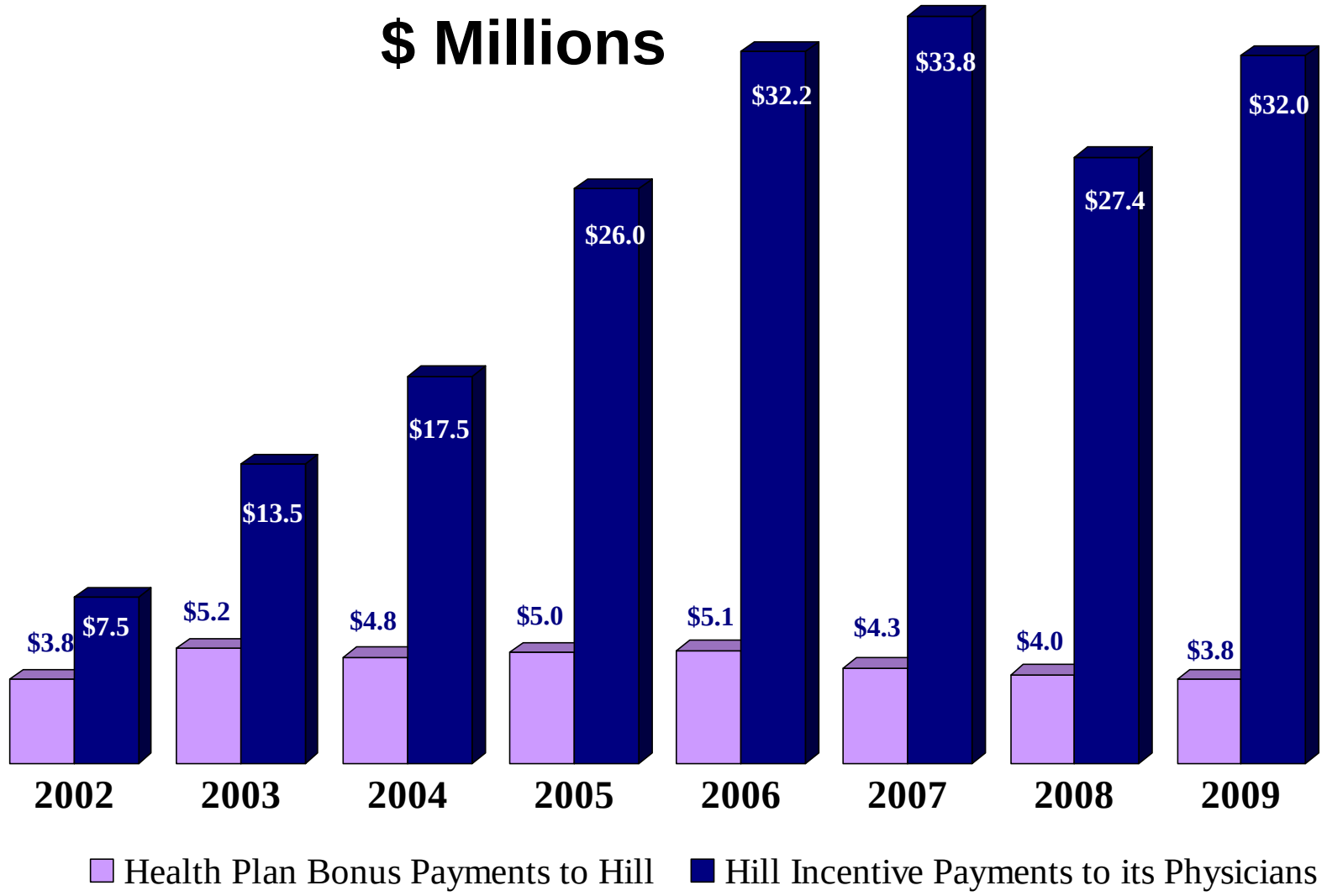
## Practice Programs

- '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



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# 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

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# 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.

# Issues/Challenges (continued)

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

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# 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.

# Issues/Challenges (*continued*)

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

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# 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

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