Understanding “Accountable Care” Models and The Rapidly Changing Healthcare Landscape

Illinois State Medical Society (ISMS) Webinar
Fall 2014
Outline for Discussion

- Defining “the new models”:
  - Clinically Integrated Networks (CINs)
  - Accountable Care Organizations (ACOs)
  - Accountable Care Entities (ACEs)
  - Bundled Payments (BPs)
  - Patient Centered Medical Homes (PCMHs)

- How this fits into what is happening in the marketplace and PPACA Implementation
  - The Marketplace Today
  - New/emerging health insurance plans/products and the deployment of these new models in those new products (commercial, Medicare, Medicaid)
  - Medicaid expansion

- Questions to ask/things to consider in positioning your organization successfully

- Open Discussion/Q&A
About PBC Advisors, LLC

- Oak Brook, Illinois–based company formed in 1986 as one of the first accounting and consulting firms focused on physician practices.
- Created 5 of the top ten independent medical groups in Chicago market.
- Manage medical groups from complete outsource to accounting, billing, payor contracting/strategy.
- Serve as Interim Executives in hospitals, medical groups, IPAs/PHOs, Provider Sponsored Health Plans.
- Leaders/early adopters in Clinical Integration, Bundled Payment, ACO, ACE program formation with clients.
- Formed SS&G Healthcare Chicago in 1995 as joint venture with Cleveland, Ohio based SS&G Healthcare.

Visit us at: [www.pbcgroup.com](http://www.pbcgroup.com)
The Marketplace Today: Transition & Transformation

Physician Hospital Silos
- Physician Hospital Integration

Employer Based or Gov’t Sponsored Healthcare Coverage
- Individual Plan Selection

Fee-For-Service “production” mentality in care delivery
- Value Based Purchasing (VBP) and Population Health Management
The Marketplace Today: Competition & Chaos

- Land grabs for primary care practices and attributed patients (market share, revenue streams, referral patterns)
- Physician Alignment strategies (CINs, ACOs, PCMHs, Employment, Group Formation)
- New Payor Contract models (HIX, VBP/P4P, Narrow Networks, expansion to governmental products)
- Small practices struggling to transition to new era (EMRs/PMs, Population Management, ICD-10)
- Hospital financial challenges (haves, have nots)
- Increased provider expenses, decreasing revenues
- Tremendous cost/efficiency pressures
The Marketplace Today: Pillars of the New Era in Healthcare

1. **Value-Based Purchasing**: All payors are moving toward reimbursing providers based on their performance, not based on negotiating leverage or brand name (FKA: P4P). Performance is driven by use of Evidence-Based Medicine (EBM) and best practices. Care delivery is migrating to standardized clinical pathways and guidelines to deliver care, and payors are linking contracts, networks and reimbursement to “quality” and “outcomes” measures.

2. **Integration & Alignment**: Starting with “100,000 Lives” report, the evidence clearly points to fragmentation of care/unaligned incentives as the biggest problem in health care delivery in the U.S. Central to all reform concepts is integration of care, and the processes, people, workflows, and technologies that provide it, including funding and reimbursement.

3. **Technology**: The technology revolution will touch all transactions and workflows (clinical, administrative, business) within the operating platform of the U.S. healthcare system (inter-organizationally, business-to-business, provider-to-patient). It is expensive and time consuming.

4. **Patient/Consumerism**: Someone else has always paid for our healthcare (Medicare, employer-sponsored coverage), so we've never had to shop for healthcare. With increased cost shift to consumers, and mandated individual insurance purchasing, we can anticipate “retail” shopping behaviors and tools to support it. Expanded coverage means more patients, enrolled in a variety of plan options. Increased focus on “wellness” and “patient engagement” models.
Moving from Volume to Value

Payment Reforms Progressively Move Away from FFS & Support Sustainable Health Care Reform

Progressively Requires Greater Risk Management, Data, Analytics
Payment Reform in PPACA Drives VBP/P4P

**Payment Models in PPACA:**
- Payment changes to support Patient Centered Medical Home and Accountable Care models
- Episode of care payments to improve quality and reduce the costs of major acute care
- Comprehensive care or global payments to improve the quality and reduce the cost of the full range of healthcare services for a population of patients

**Reimbursement Highlights:**
- Paying More for Certain Services (preventive, primary care)
- Paying Based on Quality of Services (process, outcome)
- Combining Separate Services into a Single Payment (episodic treatment payments, global payments)
- Making Payment Dependent on the Cost of Services Delivered by other Providers (resource use-based, shared savings/gain sharing)
- Paying to Support Specific Provider Structures, Systems, Locations (HIT/EMR/registry/etc, care coordination systems, geographic shortages)
How is “Value” Defined and Measured?

**Quality Components:**
- Process
- Outcomes
- Cost Efficiency
- Patient Satisfaction
- IT

**Examples:**
- PQRS
- Core Measures
- HEDIS Measures
- Chronic Care Mgmt
- Payor Initiatives
How will P4P/VBP Affect Medicine?

- Processes to support metrics: PQRS, Core Measures, CI, ACO, ACE
- Alignment of care givers, technology, care pathways, payor/provider efforts
- “Accountable Care” models (government, commercial models)
- Physician and Patient Communication
- Infrastructure needs
PPACA: Blurring Traditional Roles

Payor and Providers Compete and Collaborate

Providers enter Payor space, and vice versa

Cap

Shared-Savings Model: ACO

Episodic Bundling

Hospital–Physician Bundling

Pay for Performance
“Accountable Care” Overview
Medicare’s Movement Toward Value

Spiraling costs have led the Center for Medicare and Medicaid Innovation (CMMI) to propose various payment reforms, including:

- ACOs
- Patient Centered Medical Homes
- Bundled Payments for Care Improvement Initiative (BPCII)
“Accountable Care” Models

- Accountable Care Organizations (ACOs)
- Clinically Integrated Networks (CINs)
- Accountable Care Entities (ACEs)
- Patient Centered Medical Homes (PCMHs)
- Bundled Payments
- Global Payments

However defined, Accountable Care is dependent immediately upon Clinical Integration and Physician Alignment; and later upon Patient Engagement and Payor Partnerships
## Physician Alignment Models

<table>
<thead>
<tr>
<th>Model</th>
<th>Selective Membership</th>
<th>Care Standards</th>
<th>Coordination Infrastructure</th>
<th>Performance Management</th>
<th>Meaningful Incentives</th>
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</table>

- **No Ability**: No ability to align with the model.
- **Minimal Ability**: Minimal ability to align with the model.
- **Moderate Ability**: Moderate ability to align with the model.
- **Significant Ability**: Significant ability to align with the model.
- **Complete Ability**: Complete ability to align with the model.
Clinically Integrated Networks (CINs): Defining Clinical Integration

*Defining “Clinical Integration”:*

Globally: How doctors and hospitals work together to improve the process of care, outcomes of care, and patient satisfaction via EBM (central to CMS’ VBP initiative, CMS Core Measures, PQRI, BCBS, UHC “scores”, other outcomes measures).

For managed care contracting: How competing businesses (physicians) can *jointly contract legally*, and in turn, *market themselves to consumers* as an integrated health system (i.e., Advocate Physician Partners).

FTC/DOJ: Clinical integration can be evidenced by a network *implementing an active and ongoing program to evaluate and modify practice patterns* by the network’s physician participants and create a high degree of interdependence and cooperation among the physicians to control costs and ensure quality.

*Becoming “clinically integrated” is a must–do for any physician network seeking to do FFS contracting, and a strategy for CMS’ Global DRG Payments and ACO networks.*
The Four (4) Indicia of Clinical Integration per the FTC

Clinical Integration can be achieved via:

1. The use of common information and technology to ensure exchange of all relevant patient data
2. The development and adoption of clinical protocols
3. Care review based on the implementation of protocols
4. Mechanisms to ensure adherence to protocols

*(DOJ Statements of Anti-Trust in Healthcare, 1996)*

*Also, attorneys will tell you that you need to demonstrate “ancillarity” to contracting*
How A Typical CI Program Works

- CIN receives data from practices and other providers
- Data is aggregated in the CIN Data Warehouse
- Compliance with Evidence-Based Medicine (EBM) pathways and other metrics measured across all physicians/specialties
- CIN provides affiliated practices with tools via website/secure portal (profiler, registry)
- CIN reports patient-centric and population-based measures, physician performance linked to incentive funds/reimbursement
- Physicians incentivized to (a) use tools to proactively manage patient visits, (b) identify/treat gaps in care, and (c) update database via patient registry tools
Defining “Clinical Integration”
Typical CI Program

1. Use of Health IT:
   ◦ Utilization of e-tools/EDI
   ◦ EMR plan
   ◦ E-prescribing

2. Compliance with EBM Care Protocols:
   ◦ IP Core Measures
   ◦ OP Protocols
   ◦ Outside data sources to obtain: Hospital, Lab, Pharmacy, external providers

3. Administrative Quality:
   ◦ Patient Safety Course
   ◦ Physician Education programs
   ◦ Compliance with Re-Appointment Standards
   ◦ Generic RX prescribing
Building a Clinically Integrated Network

- Physician engagement and leadership
- Hospital commitment
- Seek excellence in vendor partners
- Network contracting
- Payor engagement
- Selection of CI Initiatives
- Meeting with the FTC
- Take the time to educate physicians and office staff on using CI/ACO tools, or they won’t
ACOs Defined

History & Evolution:

- The Dartmouth Atlas Project: Underscored broad geographic variations in cost and quality across healthcare markets.

- Medicare Payment Advisory Commission (MedPAC): Formalized the concept and featured its in June 2009 report to Congress during the development of healthcare reform.

- CMS finalized rules for participation in the Medicare ACO program on 10/20/11. Also referred to as “Medicare Shared Savings Program” (MSSP)

- In Chicago and other markets, PHOs/IPAs serve as a logical starting point for building an ACO (care management, risk sharing, claims analysis, patient engagement, etc).
ACOs Defined

The ACO Model:

- ACOs encompass a broad array of providers:
  - Physicians and clinicians (primary care focused but specialists play an important role as do mid-level providers)
  - Hospitals
  - Pharmacies
  - SNFs/LTCs

- The ACO incentivizes and rewards reductions in costs and improvement in patient outcomes using various metrics to measure success.

- ACOs may choose to participate in one of two tracks:
  - Track 1: “One sided” (upside risk/shared savings only)
  - Track 2: “Two sided” (upside and downside risk, shared savings and losses)

- Agreement period is 3 years; all ACOs that continue after the first three-year agreement must move to the two-sided model.
Accountable Care Organizations (ACOs) Shared Savings, Partial Risk, Full Risk

Source: Health Policy Briefs

EXHIBIT 2
Three Tiers Of Accountable Care Organizations And Possible Characteristics

Tier 3
- Financial Risk: High
- Mode of Payment: Full or partial capitation and extensive bundled payments
- Additional Incentives: Highest level of shared savings and bonuses if per beneficiary spending is below agreed-upon target, but greatest amount of risk if spending is above agreed-upon target

Tier 2
- Financial Risk: Moderate
- Mode of Payment: Fee-for-service, partial capitation, some bundled payments
- Additional Incentives: More shared savings and bonuses if per beneficiary spending is below agreed-upon target, but also some risk if spending is above agreed-upon target

Tier 1
- Financial Risk: Low
- Mode of Payment: Fee-for-service
- Additional Incentives: Some shared savings and bonuses if per beneficiary spending is below agreed-upon target
# Accountable Care Organizations (ACOs)

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<thead>
<tr>
<th>Quality Domain</th>
<th>Number of Measures</th>
<th>Data Source</th>
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<tr>
<td>Patient/Care Giver Experience</td>
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<td>Care Coordination/Patient Safety</td>
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<td>Claims</td>
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<td>8 total measures</td>
<td>GPRO Web Interface</td>
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<td>At-Risk Populations</td>
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<tr>
<td>Diabetes</td>
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<tr>
<td>Heart Failure</td>
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<td>Coronary Artery Disease</td>
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<tr>
<td>Hypertension</td>
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<tr>
<td>Ischemic Vascular Disease</td>
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<td>33 total measures</td>
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# Accountable Care Organizations (ACOs)

**Source:** CMS.gov

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<td>Patient/Caregiver Experience</td>
<td>ACO #1</td>
<td>Getting Timely Care, Appointments, and Information</td>
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<td>Patient/Caregiver Experience</td>
<td>ACO #2</td>
<td>How Well Your Doctors Communicate</td>
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<td>Patient/Caregiver Experience</td>
<td>ACO #3</td>
<td>Patients' Rating of Doctor</td>
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<td>Access to Specialist</td>
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<td>Patient/Caregiver Experience</td>
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<td>Health Promotion and Education</td>
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<td>Shared Decision Making</td>
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<td>Percentage of FPA who Qualified for HRR Incentive Payment</td>
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<td>ACO #22: HbA1c Control (HbA1c &lt; 8 percent)</td>
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<td>At-Risk Population Diabetes</td>
<td>ACO #27</td>
<td>Percent of beneficiaries with diabetes whose HbA1c in poor control (&gt;9 percent)</td>
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<td>At-Risk Population Hypertension</td>
<td>ACO #28</td>
<td>Percent of beneficiaries with hypertension whose BP &lt; 140/90</td>
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<td>At-Risk Population IVD</td>
<td>ACO #29</td>
<td>Percent of beneficiaries with IVD with complete lipid profile and LDL control &lt; 100mg/dl</td>
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<td>At-Risk Population IVD</td>
<td>ACO #30</td>
<td>Percent of beneficiaries with IVD who use Aspirin or other antithrombotic</td>
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<td>At-Risk Population HF</td>
<td>ACO #31</td>
<td>Beta-Blocker Therapy for LVSD</td>
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<td>At-Risk Population CAD</td>
<td>CAD Composite</td>
<td>ACO #32 – 33</td>
<td>ACO #32: Drug Therapy for Lowering LDL Cholesterol</td>
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**Notes:** PY = Performance Year
Accountable Care Entities (ACEs)

- State of Illinois/HFS Medicaid Expansion and Reform Initiatives
- ACE RFP Process
- ACE contracts awarded March 2014
- Medicaid HMO Marketing ends 4/1/14
- Migration to Managed Medicaid Models by 1/1/15
- Expansion of Managed Care plans (ICP, TANF)
- Expansion of ACEs/conversions to Managed Care Community Networks (MCCNs) or HMOs)
Accountable Care Entities (ACEs)

ACE Development & Deployment Process:

- Infrastructure & Back Office (must have one integrated reporting system across providers)
- Physician Attribution
- Patient Attribution
- First 18 months FFS with $9PMPM Care Coordination Fee
- After 18 months ACEs will be capitated, members move from Attributed to Enrolled
- After 36 months ACEs must become MCCNs or HMOs
Accountable Care Entities (ACEs)

Considerations in ACE Strategy & Deployment:

- How will physicians and patients be attributed and then enrolled?
- How will medical expenses and quality metrics be measured?
- How will achieve results with minimal funding for start up and how will I create savings?
Illinois Department of Healthcare and Family Services Health and Quality of Life Performance Measures For Accountable Care Entities

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<tr>
<th>Categories</th>
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<th>Acronym</th>
<th>Performance Measure</th>
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<td>Adults’ Access to Preventive/Ambulatory Health Services; Age 20-65</td>
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<td>Children and Adolescents’ Access to Primary Care Practitioners; Age 12 months - 19 years</td>
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<td>Ambulatory Care - ED Visits; All ages</td>
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<td>Inpatient Hospital and Mental Hospital 30-Day Readmission Rates; All ages (Diagnosis match to the 3rd digit)</td>
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<td>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents; Body Mass Index Assessment for Children/Adolescents; Age 3-17</td>
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<td>Childhood Immunization Status; completed by 2nd birthday; calculates a rate for each vaccine and combo 2-10</td>
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<td>Immunizations for Adolescents; one Meningococcal and Tdap by 13th birthday (CHIPRA_Immunization Status for Adolescents)</td>
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<td>Oregon Health and Science University</td>
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Illinois Department of Healthcare and Family Services Health and Quality of Life Performance Measures For Accountable Care Entities

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<th>#</th>
<th>Acronym</th>
<th>Performance Measure</th>
<th>Specification Source</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>18</td>
<td>CDC</td>
<td>Comprehensive Diabetes Care: Age 18-75. Annual testing; HbA1c, LDL-C and Medical attention for Nephropathy</td>
<td>HEDIS</td>
<td>Admin or Hybrid</td>
</tr>
<tr>
<td></td>
<td>19</td>
<td>PA1C</td>
<td>Annual Pediatric Hemoglobin (A1c) Testing; Age 5-17</td>
<td>NCQA</td>
<td>Admin or Hybrid</td>
</tr>
<tr>
<td>Asthma</td>
<td>20</td>
<td>MMA</td>
<td>Medication Management for People with Asthma; Age 5-64 (Report HEDIS Ages 5-11, 12-18, 19-50, 51-64 &amp; Total and CHIPRA ages 5-11, 12-18, 19-20 &amp; Total)</td>
<td>HEDIS</td>
<td>Admin</td>
</tr>
<tr>
<td>COPD</td>
<td>21</td>
<td>PCE</td>
<td>Pharmacotherapy Management of COPD Exacerbation; Age 40 and older</td>
<td>HEDIS</td>
<td>Admin</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>22</td>
<td>PBH</td>
<td>Persistence of Beta-Blocker Treatment after a Heart Attack; Age 18 and older (ACE/ARB, Beta Blocker and Discrete 80% of time)</td>
<td>HEDIS</td>
<td>Admin</td>
</tr>
<tr>
<td></td>
<td>23</td>
<td>ICHF</td>
<td>Congestive Heart Failure; Age 18 and older (ACE/ARB, Beta Blocker and Discrete 80% of time)</td>
<td>State</td>
<td>Admin</td>
</tr>
<tr>
<td>Follow-up Care</td>
<td>24</td>
<td>FLUH</td>
<td>Follow-Up After Hospitalization for Mental Illness; Age 6 and older. Two rates reported: 7 day &amp; 30 day</td>
<td>HEDIS</td>
<td>Admin</td>
</tr>
<tr>
<td>Medication Management</td>
<td>25</td>
<td>SAA</td>
<td>Adherence to Antipsychotics for Individuals with Schizophrenia; Age 19-64</td>
<td>HEDIS</td>
<td>Admin</td>
</tr>
<tr>
<td>Alcohol and Substance Abuse</td>
<td>26</td>
<td>IET</td>
<td>Initiation and Engagement of Alcohol and Other Drug Dependence Treatment; Age 13 and older</td>
<td>HEDIS</td>
<td>Admin</td>
</tr>
<tr>
<td>Maternity Measures</td>
<td>27</td>
<td>PPC</td>
<td>Prenatal and Postpartum Care; All ages. Two rates reported - Timeliness of prenatal care and Postpartum Care Rate</td>
<td>HEDIS</td>
<td>Admin or Hybrid</td>
</tr>
<tr>
<td></td>
<td>28</td>
<td>FPC</td>
<td>Frequency of Ongoing Prenatal Care; All ages</td>
<td>HEDIS</td>
<td>Admin or Hybrid</td>
</tr>
<tr>
<td>Prenatal and Post Partum</td>
<td>30</td>
<td>SICB</td>
<td>Percentage of women who delivered a low for birth weight or preterm infant who received an interconceptional bundle: smoking and alcohol screening and brief intervention, offer of effective contraception, management of chronic illness amenable to preconceptional improvement, assessment and appropriate use of osteoclast supplemetation, nutritional screening and counseling, and review and reconciliation of medications</td>
<td>State</td>
<td>Hybrid</td>
</tr>
</tbody>
</table>
Patient Centered Medical Home (PCMH)

The Premise:
- Care coordination/integration across all caregivers for chronic care management.
- Patient communication, engagement, outreach essential.
- Technology required to track patients, populations, e-prescribe, reporting, communication.

NCQA PCMH Standards:
- Access & Communication
- Patient Tracking & Registry Functions
- Care Management
- Patient Self-Management and Support
- Electronic Prescribing
- Test Tracking
- Referral Tracking
- Performance Reporting and Improvement
- Advanced Electronic Communication

Sampling of Results

**Geisinger:**
- 14% reduction in admits
- 9% reduction in total costs

**Group Health Coop/Puget Sound:**
- 29% reduction in ER Visits
- 11% reduction in admits

**Genesee Health Plan:**
- 50% reduction in ER Visits
- 15% reduction in admissions

See [www.ncqa.org](http://www.ncqa.org) for more
CMS Bundled Payment Program Overview

The “Bundled” payment combines payment for physician, hospital and other provider services into a single payment.

- Creates incentives for providers to deliver care more effectively through care coordination
- Providers may be jointly accountable and may realize a gain or loss based on how they manage resources
- Armed with information on historical costs, an organizations can begin to determine true value and/or emerging strategic issues
- It is a form of Episodes of Care Groupers or ETG’s
CMS Bundled Payment Program Overview

- Based on this data, CMS develops a historical price on a per patient basis.
- CMS contractually takes a 3% savings for the CMS program (historical price less 3% savings = Target Price (For Model 2, CMS required a minimum 2% savings).
- CMS processes all claims at 100% of allowed charges for all providers.
- The organization assumes the risk that through its management of these patients, it can reduce the total costs of post acute care costs by greater than the 3% CMS discount.
- CMS will provide a quarterly reconciliation:
  - If the sum of individual patients claim costs are less than the Target Price, the organization retains 100% of this surplus.
  - If the sum of individual patients’ claim costs are greater than the Target Price, the organization owes CMS this difference.
- Patients have to be notified that the organization is participating in CMS’ Bundled Payment Program and patients retain 100% freedom to choose any provider.
- CMS has extensive operational and quality review requirements that must be maintained.
# CMS Bundled Payment Models

<table>
<thead>
<tr>
<th>Payments of Bundle</th>
<th>Acute Care Hospital Stay Only</th>
<th>Acute Care Hospital Stay plus Post–Acute Care</th>
<th>Post–Acute Care Only</th>
<th>Chronic Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Retrospective”</td>
<td>&quot;Model #1&quot; Inpatient only All MS–DRGs</td>
<td>&quot;Model #2&quot; Inpatient, physicians and post acute providers</td>
<td>&quot;Model #3&quot; Post–acute care–bundle does not include initial acute hospital stay</td>
<td>&quot;Model #7&quot;</td>
</tr>
<tr>
<td>(Traditional FFS payment with reconciliation)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>“Prospective”</td>
<td>&quot;Model #4&quot; Hospital and physicians for acute and hospital stay only. Includes Readmission</td>
<td>&quot;Model #5&quot;</td>
<td>&quot;Model #6&quot;</td>
<td>&quot;Model #8&quot;</td>
</tr>
<tr>
<td>(Single prospective payment for an episode)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Medicare provided historical claim data for Models 2–4

* = Current, ** = Future
Bundled Payment Illustration

Calculating Medicare Payments Under BP Pilot

2008 - 09

Historical Cost Per Episode $12,200

Update Factor

CMS Discount*

* For illustration update = 3%/yr discount = 3%

BPLN Episode Definitions Risk Adjustment

2013

Target Price $13,320

Actual FFS Cost $12,900

Settlement $420

Note: CMS has not announced a method for adjusting between historical and performance period
## Bundled Payment Cost Comparison Example

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Part B</th>
<th>Home Health</th>
<th>SNF</th>
<th>Outpatient Hospital</th>
<th>Inpatient Rehab Facility</th>
<th>Other IP (Readmits)</th>
<th>DME</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital A</td>
<td>1,890</td>
<td>2,331</td>
<td>7,843</td>
<td>683</td>
<td>116</td>
<td>169</td>
<td>125</td>
<td>13,157</td>
</tr>
<tr>
<td>Hospital B</td>
<td>2,215</td>
<td>1,761</td>
<td>10,422</td>
<td>520</td>
<td>1,014</td>
<td>225</td>
<td>213</td>
<td>16,370</td>
</tr>
<tr>
<td>Hospital C</td>
<td>2,063</td>
<td>2,807</td>
<td>2,769</td>
<td>905</td>
<td>537</td>
<td>256</td>
<td>160</td>
<td>9,497</td>
</tr>
<tr>
<td>Hospital D</td>
<td>2,108</td>
<td>3,170</td>
<td>2,573</td>
<td>957</td>
<td>1,959</td>
<td>333</td>
<td>108</td>
<td>11,208</td>
</tr>
</tbody>
</table>
The Increased Importance of Payor Strategy

Demands on payor contracting and revenue cycle management increase exponentially.
Health Insurance Marketplaces (FKA Exchanges)

- Public vs. Private Exchanges
- First wave of enrollees likely the current uninsured, sick, and unfamiliar with navigating health system
- More people covered by health insurance = Increased demand for services
- Who is eligible for Marketplace coverage and affordability programs?
  - Individuals with incomes up to 138% FPL qualify for Medicaid
  - Individuals with incomes between 138% and 400% of the Federal Poverty Level (FPL) qualify for financial help for premiums and cost-sharing.
  - Cannot have access to another form of Minimum Essential Coverage (employer-sponsored insurance, Medicaid, Medicare, etc.)
  - Small Employers with 50 or fewer full-time equivalent (FTE) employees are eligible to purchase coverage through the SHOP Exchange.
- Major concerns:
  - Managing Marketshare and Payor Mix
  - Significant drop in elective utilization of specialty services
  - Significant rise in patient Bad Debt/AR
  - Risk contract models
  - “Grace Period” administration
MMAI, ICP and TANF

**MMAI/ICP (Now)**
- Aetna Better Health
- Blue Cross Blue Shield of Illinois
- Cigna HealthSpring
- Health Alliance Connect
- Humana
- IlliniCare
- Meridian
- Molina

**TANF (Coming Soon)**
- Already in: FHN, Harmony
- BCBSIL committed; other MCOs in process
- ACEs will assume some capacity
- Overlap concerns
- Ability of ACEs to manage risk in 2 years and compete with MCOs?
Insurer Product Expansion

- What does it mean for healthcare providers?
- Increased complexity & need to manage payor mix

Current – Simple

Future – More Complex
Commercial Payor ACO Models

Most commercial payors moving to:

- Additional reimbursements for “Quality” (Quality, Cost, Admin Compliance, Patient Satisfaction)
- Offering providers online access to data (claims data, patient registries)
- Future rate increases dependent upon provider performance (cost, quality, service metrics)
- Narrow networks
- Global Risk
- Expansion into Medicare, Medicaid, Individual/Insurance Exchange products

BCBS Accountable Care Contract:

- **Rules:** Clinically Integrated, EMR-enabled, provide evening, weekend hours, utilize hospitalists, submit claims data for all patients, quarterly reporting
- Total Episodic Care Management
- Formulary compliance/e-prescribing
- Referral re-direction (Blue Distinction, preferred OP Ancillary)
- Utilize BCBSIL-provided reporting tool and/or other means to identify gaps in care
- Conduct Patient Outreach for identified populations
- **Reward:** If you manage trend you share in savings
Payors Driving Consumerism and “Value” in Benefit Plans, Education

*How are consumers defining value, and who teaches them?*

- Increased product offerings: More choices are related to plan design, access, costs (narrow networks, tiered co-pays)
- “Transparency”: An effort to get patients to shop for services (costs/rates, quality metrics, administrative measures): Is the data any good? Is cost defined as rates, charges or some ill-defined hybrid?
- Patients/consumers have varying (and ever changing) definitions of value: Is expensive high quality? Is low cost low quality? Are they able to understand these “metrics” and will they make decisions with little/potential inaccurate information?
- When you do outreach to fill their “gaps in care”, is that perceived as quality or intrusive?
Where is this all headed?
Regional and National Health Systems

- Health reform encourages integration and scale:
  - Vertical integration, including as payers
  - Partnerships with payers

- Four options emerging:
  - Form a system
  - Partner in a collaborative network
  - Merge into a system
  - Prepare to shrink in isolation
Summary & Conclusion: Future State Core Competencies

1. Build or Buy Now: Scale, Brand, Physician Leadership, Strategy
2. Payor Contracting and Relationship Management (including the ability to contract for services provided on a performance basis (quality, cost; process/outcome)
3. Patient-centric and population-based care management (vertical and horizontal care management)
4. Ability to track and report outcomes and quality (and hold your own against insurers who have different data)
5. Direct to consumer marketing and enrollment
6. Capital requirements (including insurer risk reserve requirements)
7. Strong yet adaptable infrastructure
8. Connectivity via technology
9. Physician Engagement
10. Patient Engagement
Summary & Conclusion: Positioning for Success

- Know what types of networks/health systems and payor contracts initiatives that are out there that affect your organization. Understand how your organization can participate in these initiatives to support all of the above (across all flavors of “Population Health” – preventive, chronic care, surgical care, gaps in care)
- Know your metrics and how your organization’s tracks and reports (process, outcome, quality, cost, patient satisfaction) or how someone else tracks/reports your performance (payors, consumer websites)
- Know/manage your payor contracts and your referral relationships
- What kind of infrastructure do you need to manage this environment? (i.e., Patient Registries, MAs, additional admin staff)
- Project the additional potential revenues and expenses your organization has or will incur as a result of marketplace activities, opportunities and threats
- Assess how your organization works with referring physicians and affiliated hospitals to improve quality and lower cost (i.e., Clinical Integration Programs, ACOs, ACEs, “Medical Home” models); your performance can affect their performance and reimbursement/incentives
- Think about how payors and health insurance options are changing how you engage your patient population in population health management (i.e., outreach/gaps in care, preventive, follow-up)
Summary & Conclusion: Have A Strategy

- **Strategy**: Understand the world we are entering as partly ACA and partly the Wild West. We understand some of each, and some of it makes no sense. Plan accordingly.

- **Networks**: Participate in payor and provider networks aligned with your referral base. Know that sometimes what is important to you is not important to your referral base, and vice versa (i.e., Medicaid, Exchange patients).

- **Infrastructure**: Invest in the infrastructure to be able to manage a rapidly growing and diverse Payor Contract Portfolio and Patient Base, driven by VBP and Consumerism.

- **Volumes**: Assume an influx of new patients to the system; but utilization of services will likely drop. Assume less payment per service, with a greater portion of revenue will come from patients (not payors).

- **Communication**: Go above and beyond to communicate to referring physicians and your entire patient base. This drives the Patient Satisfaction scores the most.

- **Go Big**: Assess opportunities to create a bigger organization to leverage expense base, technology, revenue levers and market share.
Discussion...Questions?