

# **Health Care Reform: *Preparing for Accountable Care Organizations***

WSHA Web Cast Series: January 27, 2010  
Noon to 1:30 pm



# Presenters



Chelene Whiteaker  
WSHA



Lisa Grabert  
AHA



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MedVentive



# Setting the Stage

What will health care reform bring in the next 10 years:

- Declines in reimbursement
- Increased emphasis on quality and outcomes
- Increased integration with physicians



# Accountable Care Organizations

American Hospital Association

Lisa Grabert



**American Hospital  
Association**

# Presentation Overview

- The ACO landscape
- ACOs in the Affordable Care Act
- AHA's ACO policy development

# **The ACO Landscape**

# Where Did it all Begin?

- CMS' Physician Group Practice (PGP) Demonstration
- 10 PGPs → 8 included a hospital
  - Billings Clinic
  - Geisinger Clinic
  - Forsyth Medical Group
  - Park Nicollet Clinic
  - St. John's Clinic
  - Middlesex Health System
  - Dartmouth-Hitchcock Clinic
  - University of Michigan Faculty Group Practice
  - Marshfield Clinic
  - The Everett Clinic

<http://www.cms.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=3&sortOrder=descending&itemID=CMS1198992>





# Current Efforts – Brookings/Dartmouth

## Brookings/Dartmouth Collaborative

<https://xteam.brookings.edu/bdacoln/Pages/home.aspx>

 <b>NORTON</b> HEALTHCARE	<b>HUMANA®</b>
 <b>HealthCare™</b> <b>PARTNERS</b> MEDICAL GROUP	<b>Anthem</b> 
 <b>TMC</b> HEALTHCARE	 UnitedHealth Group
 <b>Monarch HealthCare®</b> A MEDICAL GROUP, INC.	<b>Anthem</b> 
<b>CARILION CLINIC</b>	<b>TBD</b>

# Current Efforts

- State Initiatives
  - Colorado
    - Regional Care Collaboratives for Medicaid
  - New Jersey
    - <http://www.njleg.state.nj.us/bills/BillView.asp>
  - Massachusetts
    - Pending legislation – January 2011
- Certification/Accreditation
  - National Committee on Quality Assurance
  - The Joint Commission - Pending

# **ACOs in the Affordable Care Act**

# Affordable Care Act (ACA)

- Section 3022 and 10307 of ACA
  - **Medicare Shared Savings Program**
    - Begins January 1, 2012
    - Accountable for the overall care for beneficiaries
    - Sign a 3-year agreement
    - Must have at least 5,000 attributed beneficiaries
      - No lock-in
    - Defined set of quality measures to be reported
      - Step #1

# ACA

- Section 3022 and 10307 of ACA
  - **Medicare Shared Savings Program**
    - Shared savings, after adjusting for random variation
      - Formal legal structure for distributing shared savings
    - Option to use additional risk models including partial capitation
    - Physician Group Practice (PGP) demonstration participants may convert and ACOs
    - Working with other payers gets preference

# ACA

- Section 2706 of ACA
  - **Pediatric ACO Demonstration**
    - Begins January 1, 2012
    - 5-year demonstration
    - States must apply to participate
      - Each state will award 3-year agreements
  - The Secretary will work with each state to establish the savings benchmarks



# ACO Implementation

- Medicare ACO Program
  - Set of Questions and Answers on ACOs
    - <http://www.aha.org/aha/issues/Health-Reform/reform-moving-forward.html?group=hospital>
  - Open door forum on June 24, 2010
  - Request for Information on December 3, 2010
    - [http://www.aha.org/aha\\_app/letter/archive.jsp](http://www.aha.org/aha_app/letter/archive.jsp)
  - Timing of ACO proposed rule/interim final rule with comment

# ACO Implementation

- Pediatric ACO Demonstration
  - National Association of Children's Hospitals and Related Institutions
    - [http://www.childrenshospitals.net/AM/Template.cfm?Section=Key\\_Issues1&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=55008](http://www.childrenshospitals.net/AM/Template.cfm?Section=Key_Issues1&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=55008)

# **AHA's ACO Policy Development**

# AHA ACO Policy Development

- Discussions with over 500 senior hospital leaders
  - Learning collaboration with PGP demonstration participants
  - Fall Regional Policy Board (RPB) discussion
  - Case Studies
    - Interviews with four organizations
      - Synthesis policy report
      - Synthesis infrastructure report

# AHA ACO Policy Development

- Regional Policy Board Findings
  - Focus on accountable care first, organization second
  - Considerations for rural providers
  - Lack of timely data and lack of beneficiary lock-in are the two biggest barriers
  - Coordinate federal, state and private-payer ACO initiatives

# AHA Policy Development

- Case Studies
  - Four cases:
    - Physician-only
    - Large system (22,000 employees)
    - Sole community hospital
    - Small system affiliated with an Independent Practice Association (IPA)

# ACO Case Studies - Take Away #1

## Key Strategic Question:

When is the right time to “flip the switch” between the two different payment worlds?



# ACO Case Studies - Take Away #2

## Key Strategic Question:

How do you demonstrate that your system is ready to take on risk?



## *Legislative* Advisory

Hogan  
Lovells

May 11, 2010

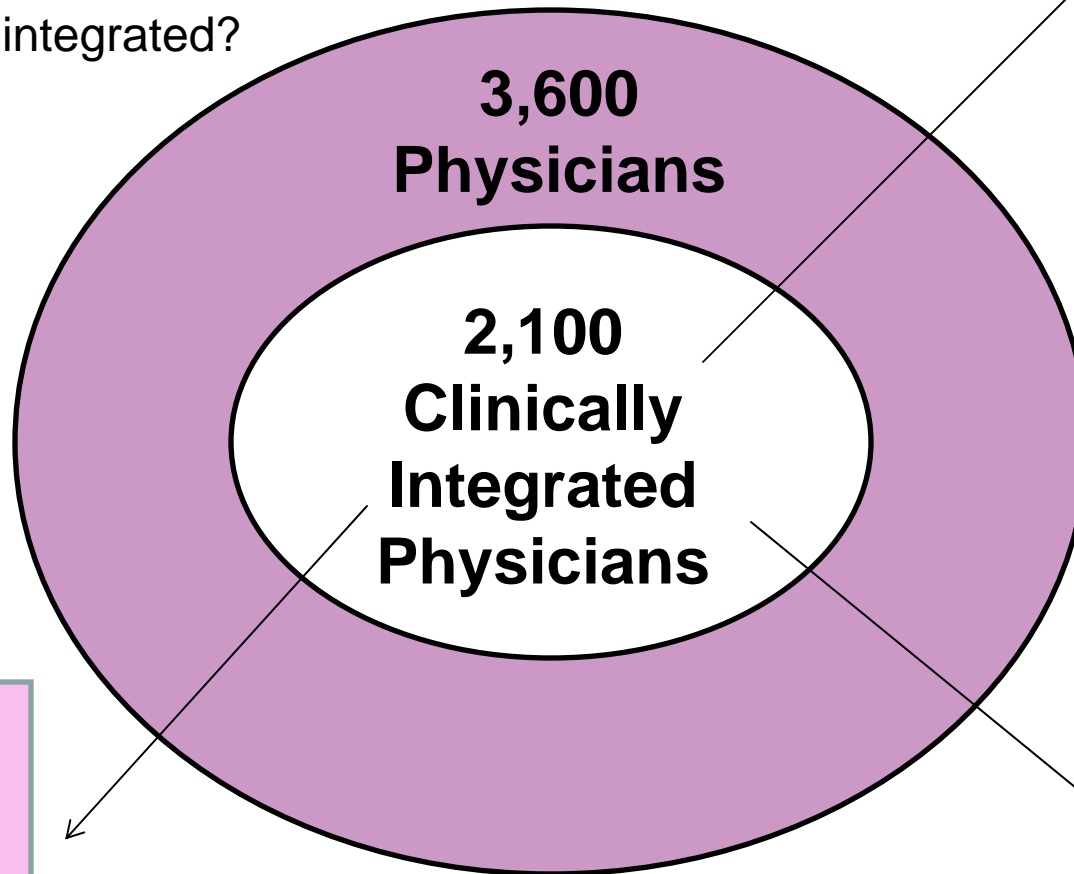
### **SUMMARY OF THE MOST SIGNIFICANT HEALTH REFORM CHANGES AFFECTING HOSPITALS AND OTHER EMPLOYERS**

<http://www.aha.org/aha/advisory/2010/100511-legislative-adv.pdf>

# ACO Case Studies - Take Away #3

## Key Strategic Question:

What does it mean to be clinically integrated?

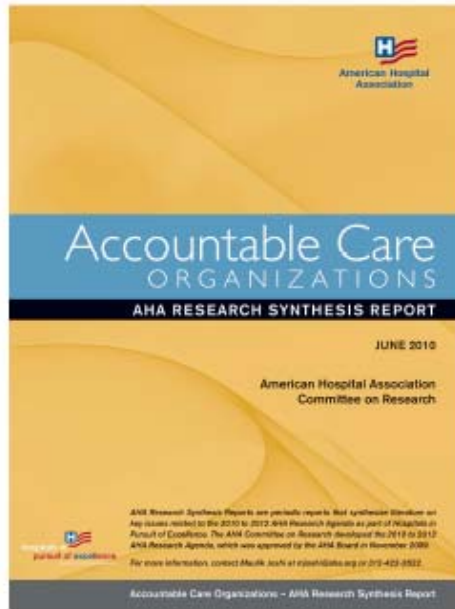


Use of an electronic health record

Follow Evidence Based Medicine

Submit quality measures

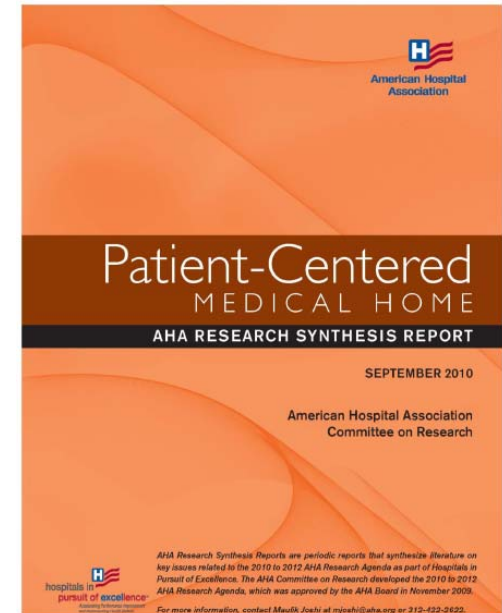
# AHA Research Synthesis Reports



## ACOs

- June 2010
- Sample pilot efforts
- Key issues for consideration

<http://www.hret.org/accountable/index.shtml>



## Medical Home

- September 2010
- Current federal, state and private sector efforts
- Considerations for beginning a medical home

<http://www.hret.org/patientcentered/patient-centered.shtml>

# Some Unanswered Questions

- Must an ACO have a medical home?
- How will beneficiaries be assigned to each ACO?
- Will providers be able to offer incentives to beneficiaries to stay within the ACO?
- How will the benchmarks be calculated?
- What level of savings must be achieved before additional savings can be shared?
- How much risk will ACOs be required to accept?
- How will hospitals/physicians in rural and small communities be able to participate?



# **Critical Elements of an ACO and How to Ensure Positive ROI**

Nancy Ham  
*President and CEO*

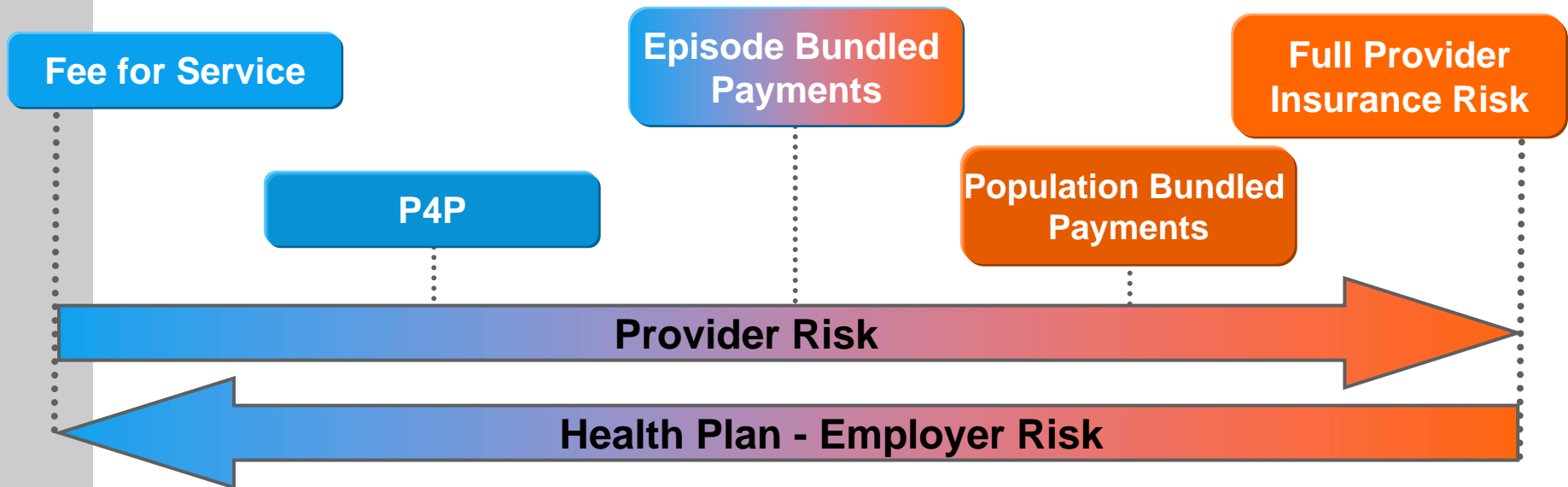
# Our Background Explains our Passion...

- Began in 1997 as part of CareGroup managing 450,000 full risk capitated lives:
  - Developed fully integrated suite of tools to manage our medical expense and improve the quality of care
  - Integrated multiple third party engines to assure best of breed expert systems
  - Came to focus on communication and engagement capabilities as key to driving change
  - Spun out technology in 2005 as MedVentive
- Recognized for breakthroughs in cost & quality:
  - Microsoft HUG Award for Interoperability
  - U.S. Dept. of HHS
  - AIM Award



# Change is Inevitable

- With the backdrop of health reform, **change is inevitable** in the form of reimbursement and new care delivery models.
  - Financial risk will shift from health plans to providers for managing populations of patients on a cost and quality basis



# Change is a Good Thing

Standing still is a risk too  
Opting out of risk is not a good option

## Non-risk FFS contracts result in:

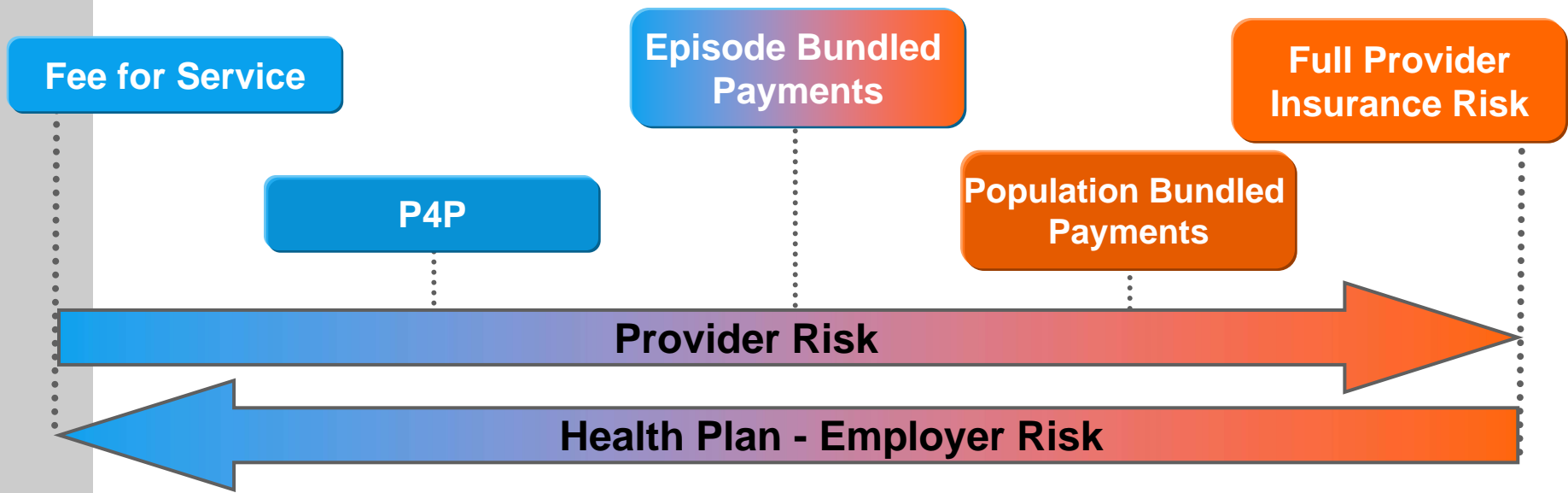
- Deeply discounted fee schedules
- External controls for resource mgmt
- Case/referral management
- RBMs
- Specialty carve-outs with limited provider networks

## Risk Contracts allow for:

- Provider-centric care management
- Surplus potential

# Change has Many Faces

- Don't limit your thinking of risk as an all or none phenomenon.
  - Where on this spectrum will you do best?
  - Is a hybrid deal an option? Can you get more money by taking “some” risk? Risk with protection?
  - Assess each payer carefully for the right deal



# Change Requires Investment

- Leadership support and shared expectations
- Define effective organizational structure
- Payer contracting expertise
- Physician compensation incentives
- Population-based medical management
- Ability to turn data into insights and actions into results

# **Practical Approach to Ensure Success and a ROI**

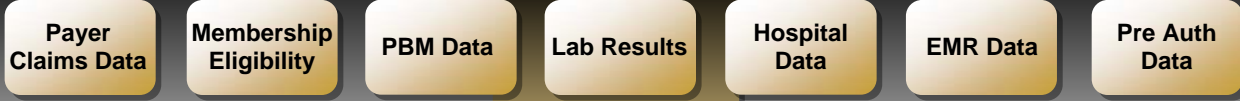
# ROI Starts with Internal Efficiency

- Address barriers: legal, heterogeneous performance, desire for autonomy, politics & governance
- Consolidate / standardize infrastructure and governance in a phased approach:
  - Reduce duplicate committees and boards
  - Consolidate credentialing, contracts/payments, audits
  - Realize infrastructure efficiencies of scale
    - Move to no Executive Directors -> maintain local Medical Directors
  - Fewer meetings and physician time
- Invest in shared IT infrastructure
  - Merge support functions – data management

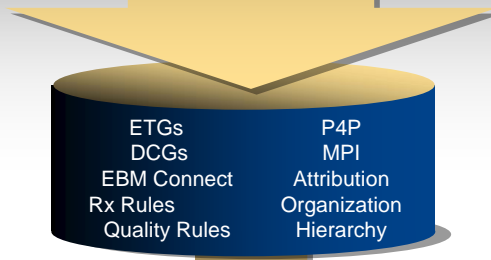
# ROI Starts with Smart Contracting

- Shared risk, not inflicted risk:
  - Surplus potential with reasonable utilization goals
  - % of premium model, with severity adjustment
  - Segregating/minimizing uncontrollable risk
- **Funding by payers for MSO functions (33-100% of MSO budget)**
- Ability to accept and manage delegated functions:
  - Medical management, case management, referral management, and precertification
  - Credentialing
- Foster active collaboration with the plans
  - **Data, data, data**
  - Timely and frequent settlements to MSO & payments to providers

# Technology Is A Key ROI Driver

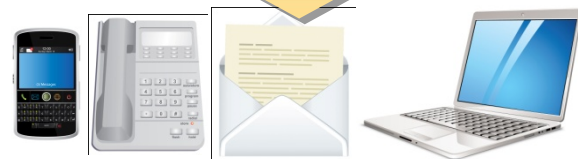


## Data Acquisition



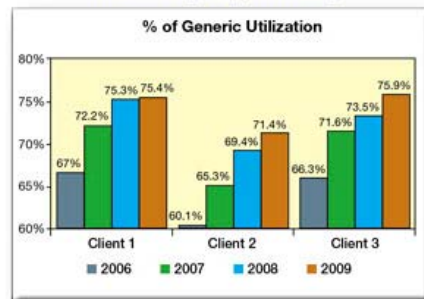
## Insight

## Action

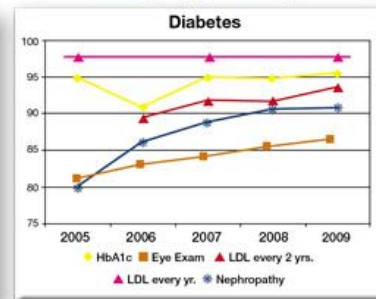


## Results

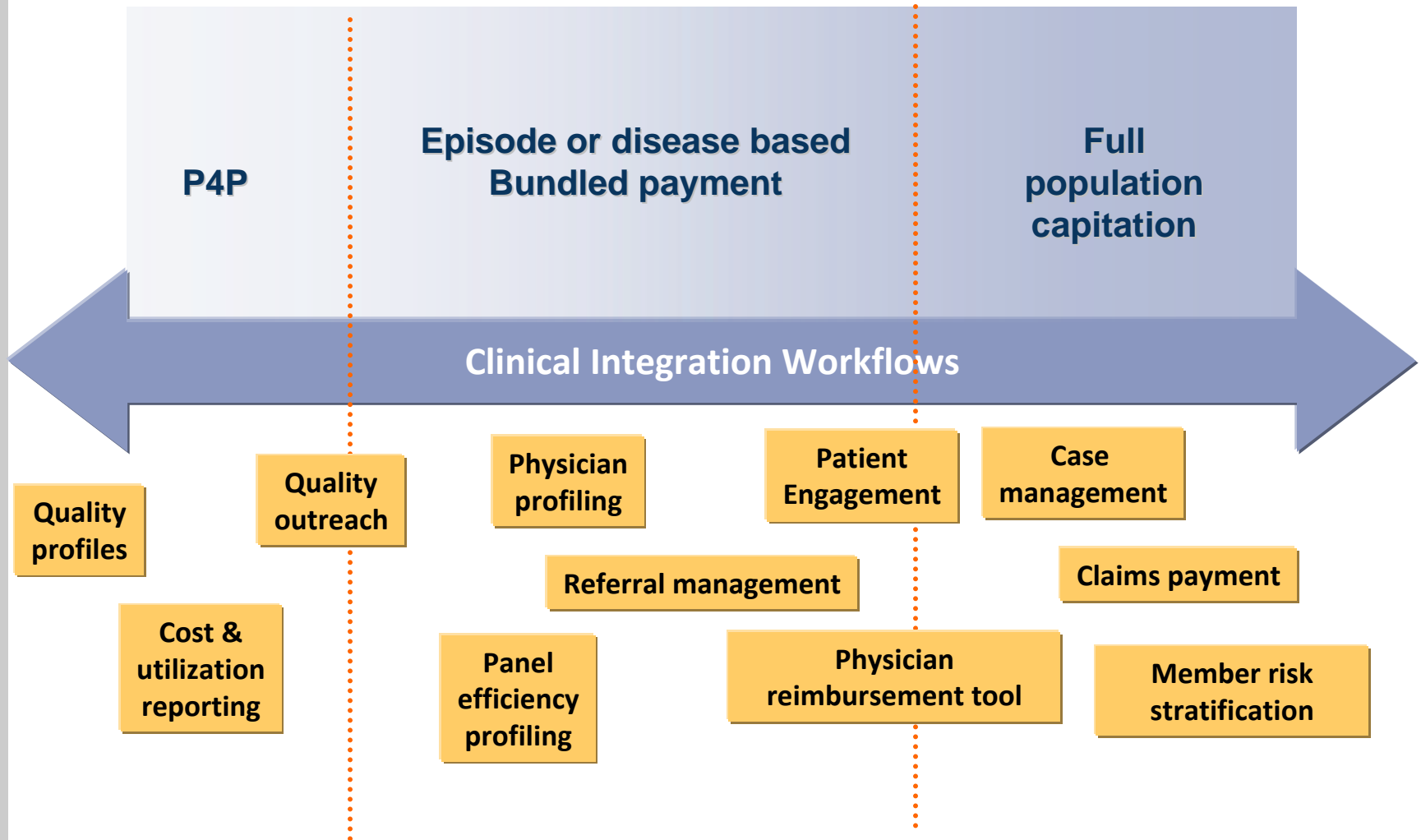
Pharmacy Opportunity



Quality Opportunity



# Increased Risk Requires More Complex Analytic Tools



# Physician Performance Profiling

## Target Areas

- |   |   |
|---|---|
| <ul style="list-style-type: none"> <li>PCP Efficiency Profile Graphs</li> </ul>     | <ul style="list-style-type: none"> <li>PCP Efficiency Profile Detail Reports</li> </ul> |
| <ul style="list-style-type: none"> <li>Specialist Efficiency Profiles</li> </ul>    |   |
| <ul style="list-style-type: none"> <li>Quality Registries &amp; Profiles</li> </ul> |   |
| <ul style="list-style-type: none"> <li>Patient Risk Stratification</li> </ul>       |   |
| <ul style="list-style-type: none"> <li>Leakage</li> </ul>                           | <ul style="list-style-type: none"> <li>Inpatient Usage</li> </ul>                       |
| <ul style="list-style-type: none"> <li>Emergency Room Detail</li> </ul>             | <ul style="list-style-type: none"> <li>Emergency Room Frequent Flyers</li> </ul>        |
| <ul style="list-style-type: none"> <li>Outpatient Imaging</li> </ul>                | <ul style="list-style-type: none"> <li>Outpatient Visits</li> </ul>                     |
| <ul style="list-style-type: none"> <li>Drug Profile - PCPs</li> </ul>               | <ul style="list-style-type: none"> <li>Drug Profile - Specialists</li> </ul>            |

## PCP Drug Utilization Profile

**BELCHER, JAQUELINE M.D.**  
 Pod: Franklin Medical Group  
 PCP Type: Family Practitioner  
 Avg Panel Size: 126  
 YTD Member Months: 758

	PCP Panel	PCP Panel	PCP = Prescriber	PCP = Prescriber	Comparison Group*	Comparison Group*
	2009Q2	2009 - YTD	2009Q2	2009 - YTD	2009Q2	2009 - YTD
Total Rxs	773	1,432	293	531	9,329	18,409
Avg \$Rxs	\$70.99	\$69.90	\$79.10	\$75.49	\$64.15	\$65.00
Rx per 100 Mbrs	200.8	188.9	N/A	N/A	246.5	243.0
Total Rx Cost	\$54,873	\$100,091	\$23,178	\$40,084	\$598,454	\$1,196,550
Cost PMPM	\$142.53	\$132.05	\$60.20	\$52.88	\$158.11	\$157.94
Formulary Compliance	93.0%	92.9%	95.4%	95.4%	92.6%	92.5%
Generic Utilization	75.9%	75.9%	78.5%	78.9%	76.5%	75.9%

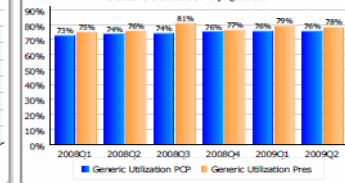
\*Comparison Group is based on the local cluster, and includes only PCPs of the same type (i.e., Internists, pediatricians or family practitioners). If the PCP's type is unknown, then Comparison Group will include all PCP Types.

### Trend Graphing (Last Six Quarters)

Cost PMPM By Quarter (\$)



Generic Utilization By Quarter



Formulary Compliance By Quarter



Data includes Payer(s) 17  
 Details include PCP-level data for all prescribers for patients in the profiled PCP's panel. PCP Panel Cost PMPM reflects total prescription costs per member per month for all prescriptions written by all prescribers for the profiled PCP's panel. Results in labeled PCP = Prescriber include only prescriptions written by the profiled PCP (excluding prescriptions written by other prescribers for the profiled PCP's panel). Formulary Compliance rate equals the number of prescriptions for formulary drugs divided by the total number of prescriptions. Generic Utilization rate equals the number of prescriptions for generic drugs divided by the total number of prescriptions written. When a drug is available in both a brand and generic form, the generic utilization rate indicates the percent of times the generic form was dispensed. The validity of decisions based on calendar month data included with the number of number of number. Incomplete suggests that profiles with less than 1,000 member months are subject to small number variation.

# Address the Confidence Killers



**“My patients are sicker”**

**“I had an outlier patient who was in the hospital for 6 months”**

**“This is not my patient”**

**“This patient shouldn’t be in this registry”**

**“This guideline isn’t applicable to this patient”**

- **Sophisticated methodology**
- **Physician feedback loops**
- **Supplemental data**

# Create Tactical-Practical Action Plans

- You can't boil the ocean
- Use your analytics to identify 5-10 areas of targeted improvement, with a mix of quality & financial goals
- Invest in central staff: data, quality, case mgt, pharmacy
- Gain physician confidence:
  - Secure your clinical champions
  - Start publishing & explaining data long before you tie \$\$ to it -> need buy-in to measurements
- Have clear incentive plans



# Success Stories

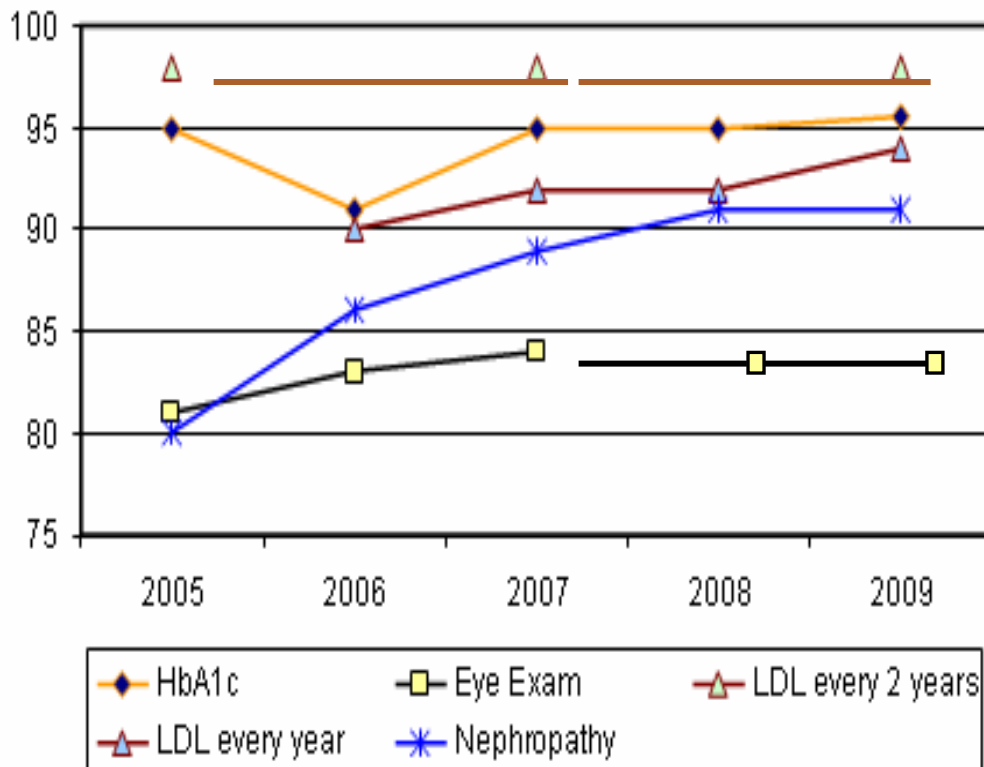
# Case Study: PHO

- Environment:
  - 2 hospital system; IPA with 315 physicians and 115 practices
  - 50,000 patients
  - Risk contracts with 4 major payers
  - Robust technology environment (GE Centricity & Meditech)
  - Clinical team: case management, pharmacist & quality manager
- Needed:
  - Enterprise oversight and reporting
  - Creation of population management and all-payer registries
  - Integration of lab, EMR and pharmacy data
  - Decentralized system to engage physicians and care coordinators... create distributed disease management
  - Cubes and data mart for power financial analytics

# Quality Improvement Results

Quality results above the 90th percentile nationally for Diabetic care, adult & pediatric preventive care, women's health and cardiovascular disease

## DIABETES



MEASURES	PHO	HEDIS National 90 <sup>th</sup> percentile
HbA1c Screening	94.6%	93.2%
Eye Exam	84.0%	72.0%
LDL C Screening	92.1%	88.8%
Medical Attention for Nephropathy	88.9%	87.8%

# Financial Results

- Pharmacy:
  - Generic utilization above 75%
  - Saved \$2M in pharmacy across total population
- Other highlights:
  - Frequent flyer report to manage ED costs
  - Leakage reports to analyze referrals to tertiary centers
    - Physician & patient engagement
  - Thousands of manually-entered supplemental data points each year

# ROI Example

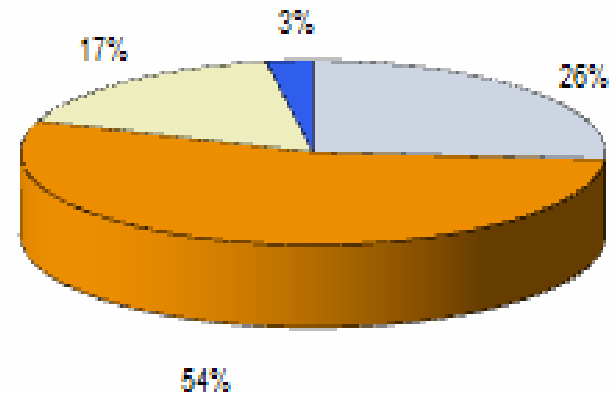
## Anticipated ROI

- 3X ROI, 7 benefits
- Good breadth and distribution

## Top benefits (Annual Value):

- Maximize generic utilization through patient specific drug interventions = \$1.7M
- Contain medical expenses through physician efficiency profiling and outreach = \$1.0M
- Better manage chronic disease populations to optimize quality and cost of care = \$750K
- Protect patient retention through consistent public quality reporting = \$680K
- Protect ability to hit incentive targets = \$500K

Payback period:	10.5 months
3 Year ROI:	276%



- Control Pharmacy Costs
- Optimize Quality Performance
- Reduce Utilization
- Increase Operational Capacity

# Additional Resources

## Washington State Hospital Association www.wsha.org

The screenshot shows the Washington State Hospital Association website. The header includes the logo and the tagline "Improving Quality. Increasing Access." Below the header is a navigation menu with categories: About WSHA, Policy / Advocacy, Quality & Safety, Events & Education, and Hospital Issues. The main content area features a "POLICY / ADVOCACY" section with a sub-section for "Federal Health Reform". The article text discusses the Patient Protection and Affordable Care Act (ACA) and its impact on hospitals. A sidebar on the left lists various policy and advocacy resources.

**Washington State Hospital Association**  
Improving Quality. Increasing Access.

Home | News | Healthcare Links | Site Map | Search

About WSHA | Policy / Advocacy | Quality & Safety | Events & Education | Hospital Issues

**POLICY / ADVOCACY**

- Federal Health Reform
- Inside D.C.
- Washington's Congressional Delegation Contacts
- HITECH Update
- Legislative Calendar
- Medicaid News
- Medicare News
- Policy/Advocacy Agenda & Issue Briefs
- Policy/Advocacy Team
- Special Reports
- State Budget Shields Safety Net
- Top Priority Policy Objectives
- Contact Your Legislators

### Federal Health Reform

In the largest single expansion of health insurance since enactment of Medicare and Medicaid, Congress enacted the Patient Protection and Affordable Care Act (H.R. 3590) and the Health Care and Educational Affordability Reconciliation Act (H.R. 4872). Congress had been working for more than a year on health care reform, with both houses having passed similar, but different approaches to reform in November and December 2009. The federal law provides broad concepts and direction, though much of the implementing detail over the next couple of years will come through the regulatory process. The Washington State Hospital Association will continue to analyze the impacts on hospitals.

When fully implemented, the health care reform law will extend health insurance to about 32 million people. About 95 percent of legal residents or 92 percent of people residing in the country will have health insurance or coverage. The cost of the reform package is about \$940 billion over 10 years, financed through cuts to health care providers and new taxes.

### Communication Materials

- WSHA Model Powerpoint Presentation
- AHA Talking Points for CEOs

The screenshot shows the American Hospital Association website. The header includes the logo and the tagline "Our Vision is of a society of healthy communities where all individuals reach their highest potential for health." Below the header is a navigation menu with categories: About, Advocacy, Issues, Research and Trends, News Center, Member Center, Resource Center, and Associates. The main content area features a "HEALTH CARE REFORM" section with a sub-section for "Moving Forward". The article text discusses the impact of the ACA on hospitals and the role of the AHA. A sidebar on the right lists various health care reform resources.

**American Hospital Association**  
Our Vision is of a society of healthy communities where all individuals reach their highest potential for health.

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About | Advocacy | Issues | Research and Trends | News Center | Member Center | Resource Center | Associates

### HEALTH CARE REFORM

Moving Forward

Click image to view Health Reform Information

hospitals in pursuit of excellence

Click to Learn More

### What's New

Advisory: Hospital Value-Based Purchasing Program: The Proposed Rule

Health For Life: Better Health Better Health Care Brochure

AHA, other hospital associations file amici brief in ACA case

Letter: AHA Comments Re: President's Council of Advisors on Science and Technology Report

Guide: Contracting for Electronic Health Records: Guidelines for Hospitals

More What's New ...

**HIGHLIGHTS**

- Schedule H Practice Website: An Educational Tool -- AHA Members Only
- Post-Election Message -- AHA Members Only
- Community Connections

INSIGHT | SERVICES | CALENDAR | AHA News

## American Hospital Association www.aha.org

**Comments and Questions?**

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