The Financial Blueprint for Accountable Care

Daniel J. Marino, Health Directions, LLC
Meredith Duncan, Seton Health Alliance

Agenda

• Overview of accountable care and building clinical integration
• Building the Pioneer ACO
• Working Session:
  – Building Accountable Care and a Clinically Integrated Network
• Summary
The Essential Problem: Lack of Innovation

“The cause of runaway healthcare costs is malpractice—but not the medical kind. Rather, we’re guilty of business model malpractice on a grand scale.”

Clayton Christensen, Harvard Business School, Author of ‘The Innovators Dilemma’

Building Blocks of Clinical Integration

- Cohesive network of physicians and hospitals with aligned incentives
- Physician leadership and engagement across key specialties
- Governance structure/FTC definition of CI
- Process for monitoring quality outcomes and aggregating data
- Health information technology platform to support care management
- Value-based payer contracts (shared savings, partial/full risk)
- Strong culture around coordinated care management
Clinical Integration Networks (CINs) are emerging across the country with goals that include:

- Increasing the organized system of care beyond primary target markets
- Driving more members into organizations through value-based or narrow network contracts
- Creating contracts focused on reimbursement for quality (value-based care)

CINs have the ability to:

- Influence payer and direct-to-employer contracts and drive members into organizations
- Expand care management capabilities by creating quaternary and tertiary relationships and specialty programs of excellence

Overview of Clinical Integration Networks

Creating the Burning Platform for Change

“Clinically Integrated Care”

Poised for a shift to value-based care

Member Alignment Objectives

- Create common vision for change
- Create new care delivery models
- Engage payers and employers in fee-for-value contracting
- Capitalize on provider value-based initiatives
Elements of Clinical Integration

Movement to Clinically Integrated Care

Key Drivers

- Coordinated Care Management
- Expand Covered Lives
- Minimize Leakage
- Population Health Capabilities
- Leverage Infrastructure
- Expand Patient Access

Establishing a CIN is Based on a Variety of Factors that are Market-Specific

Market Pace of Change

CIN

Fast

Fast / Moderate

Moderate

Moderate / Slow

Slow
Overview of Clinical Integration Network Collaboratives

• CI Collaboratives have the ability to:
  – Allow a large provider CIN to expand membership to providers in second and third tier markets
  – Influence payer and direct-to-employer contracts to drive members into organizations
  – Expand care management capabilities by creating quaternary and tertiary relationships and specialty programs of excellence
  – Incorporate economies of scales around CI infrastructure, GPO services and supply chain activities
  – Increase the organized system of care beyond primary target markets
  – Build additional revenue streams

The Evolution of Clinically Integrated Care

<table>
<thead>
<tr>
<th>Phase 1</th>
<th>Develop the Clinical Integration Network</th>
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<tbody>
<tr>
<td>• Build the CI network infrastructure</td>
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<td>• Build the CI culture with the CIN and providers</td>
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<tr>
<td>• Establish quality programs, incentive models and outcome tracking</td>
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<tr>
<td>• Develop care management infrastructure</td>
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<td>• Enter into limited risk-based contracts</td>
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<td>• Build analytics and IT capabilities</td>
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Revenue opportunities through savings: 5-10%

<table>
<thead>
<tr>
<th>Phase 2</th>
<th>Create CI Collaborative</th>
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<tbody>
<tr>
<td>• Leverage infrastructure with providers in new markets</td>
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<tr>
<td>• Develop products</td>
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<td>• Partner with payer(s) (carrier as the middle-man)</td>
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<tr>
<td></td>
<td>- Larger provider network</td>
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<td></td>
<td>- Access to membership</td>
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<td></td>
<td>- Direct to employer contracts</td>
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<td></td>
<td>- Shared risk arrangements</td>
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<tr>
<td>• Care transformation services</td>
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Revenue opportunities through savings and new revenue streams: 10-20%

<table>
<thead>
<tr>
<th>Phase 3</th>
<th>Provider Sponsored Health Plan</th>
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<tbody>
<tr>
<td>• Full Service Provider of ACO Services</td>
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<tr>
<td>• Offer insurance products direct to the market</td>
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<tr>
<td>• Commodity products and services direct to employees/patients</td>
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<tr>
<td>• Full risk-contracting with employers</td>
<td></td>
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<tr>
<td>• Advanced benefits designs and administrative services</td>
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<tr>
<td>• Care optimization services</td>
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Revenue opportunities through risk arrangements, service offerings: 10-15%
Clinically Integrated Care: Risk Versus Capabilities

The immediate strategic imperative is to build a baseline infrastructure and transitional capabilities that will aid the development of value-based care.

Risk Assumed
- High
- Moderate
- Low

Capabilities
- Provider sponsored health plan
- Provider network development
- Quality programs
- Referral management
- Cost management
- Risk-contracting evaluation
- Analytics, reporting and monitoring
- Care management
- Care/ utilization management
- Total cost of care management
- Risk-contracting evaluation
- Analytics, reporting and monitoring
- Care management

Strategy
- Transition to full risk contracts directed to employers with the focus on further reductions of "cost of care"
- Expand CIN to a regional collaborative with the addition of provider organizations to drive membership
- Develop clinically integrated network with focus on provider network development and value-based contracts

Options for a CI Collaborative and Payer Partnership

CI Collaborative Contribution
- Clinical programs / interventions
- Care management
- Oversee and manage the clinical integrated network
- Population health analytics
- Reimbursement and incentive distribution models
- Benefits administration

Payer Partner’s Contribution
- Relationship with employers in tier 2 and tier 3 markets
- Drive membership into collaborative
- Access to capital support
- Share in risk with employers
- TPA services
Building the Collaborative’s Imperative

Must define common vision, required capabilities and implementation priorities to meet short-term objectives while building the infrastructure for long-term goals

Financial Opportunities for Clinically Integrated Care

Financial Impact Drivers

- **Infrastructure Cost Savings**
  - Reduce costs through shared management services and care management infrastructure
  - Low IT infrastructure and support costs
  - Move toward a lower PMPM cost of care model removing 20% to 45% over 5-10 years
- **Drive New Membership**
  - Collaborative product offerings with payers
  - Narrow network contracts with payers, employers
  - Discount pricing of clinical services or programs to other CI provider members
- **Increase Domestic Utilization**
  - Minimize member out-of-network leakage
  - Steer members to a hospital (Tier 1) or collaborative network (Tier 2)
- **Expand Clinical Service Offerings**
  - Offer “clinical excellence” service programs (i.e. Advanced Pediatric Services) to Collaborative
  - Expand Organized System of Care opportunities
Enterprise Transition to Risk Timing

Market Pace of Change

Maximize Value

Provider Market

Minimize Risk

Risks with Moving Too Fast

• Reduced reimbursement rates
• Lower utilization driven by own organization
• Limited gains in market share for being low cost / high quality relative to market
• Unnecessary infrastructure investment

Risks with Moving Too Slow

• Lost market share through tiered/narrow networks
• Reduced utilization driven by other organizations
• Inability to capture dollars for reduced utilization
• Limited leverage for aligning other providers
• Allows others to dictate your future

Align Physician-Hospital Incentives with Technology

Industry pressures are driving physicians and hospitals toward tighter alignment models

Hospital / Health System Point of View

Tighter alignment with physicians helps hospitals / health systems by:
• Securing referral channels
• Strengthening tertiary programs
• Extending the system’s network to better manage a population (attributable lives for risk-based models)
• Allowing capture of some percentage of technical fees that migrated to physician offices

Physician Point of View

Tighter alignment with hospitals helps physicians by:
• Providing income security and growth potential (through employment salary or improved reimbursement via a PHO or non-employed model)
• Gaining access to capital (e.g., for EMR investment)
• Accessing assistance with practice growth or succession
• Connecting the practice to a larger network of physicians for shared initiatives (e.g., quality)
Using Data to Build the Value Proposition

Building an attractive value proposition for the network is critical to meeting the clinical integration goals.

**Objectives:**
- Establish the CIN as the preferred alignment vehicle in our area
- Develop sufficient benefits to encourage physicians to join today

**CI Value Proposition Components**

<table>
<thead>
<tr>
<th>Economic</th>
<th>Clinical</th>
<th>Value-Added Services</th>
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<tbody>
<tr>
<td>Mechanisms to reward physicians for delivering increased value including access to new payment models and patient populations</td>
<td>Tools, data, capabilities, and resources to elevate delivery of care by increasing quality and lowering overall cost</td>
<td>Additional benefits to ease the challenges facing independent practitioners in today’s environment</td>
</tr>
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Case Study of An Accountable Care Organization
**Background**

- Large hospital system and large independent multi-specialty group come together to form an ACO
- Minimal clinical integration exists between the hospital and physician group
- Apply to participate in CMS ACO program with 14,000 beneficiaries
- ACO providers reimbursed on a FFS model with the opportunity for shared savings

**Where Does the ACO begin?**

- Establish shared governance
- Define compact between provider & ACO
- Outline capabilities needed and infrastructure requirements
- Evaluate the ACO population cohort
- Build care management programs to manage the population cohorts
- Identify the data and technology required to support the ACO
- Build the ACO performance reporting platform
ACO Model Components

- **Beneficiary Alignment**
  - Aligned with physicians based on who billed for plurality of primary care allowed charges over 3 year period.
  - Beneficiaries can opt out of data sharing.
  - Minimum of 15,000 beneficiaries to qualify for program.

- **Payment Model**
  - Providers continue to be paid FFS by Medicare.
  - All payments associated with aligned beneficiaries are reconciled against a predetermined cost target to determine shared savings/losses.

- **Clinical Programs**
  - The ACO must develop clinical programs that A) demonstrate patient centeredness; B) improve access; C) coordinate and align care; D) avoid unnecessary care (hospitalizations, ED, readmits, etc.); E) are cost effective.

- **No Network Boundaries**
  - Beneficiaries have open access to all providers participating in Medicare.
  - ACO cannot restrict access.

- **Quality Measurement**
  - ACOs must report and will be measured against a set of quality and CAHPS metrics.
  - Shared savings will be prorated on these metrics.

- **Health IT**
  - ACO must attest that 50% of its PCPs have met requirements for attestation for meaningful use.

Elements of ACO

- **Performance Management**
  - Population analytics/predictive modeling
  - Understanding of beneficiary mix related to cost of care, cost increases and distribution
  - Proactive management of costs and outcomes

- **Care Management**
  - Programs, interventions and care gap management
  - Management of care within cohort groups, process and protocols, structures and roles
  - Interventions and outcomes

- **Technology Infrastructure**
  - Support a patient longitudinal record
  - Integrate data and coordinate care

- **ACO Reporting**
  - Track internal patient outcomes
  - Performance related to 33 ACO measures
  - Intervention or program reports
Importance of Performance Management

- Population analytics and predictive modeling tool is required to understand our ACO cohort
  - Breakdown of cohorts by risk category (end of life, high, medium and low risk)
  - Comparison of ACO cohort to community and national population
- Helps to understand the two types of inherent risk categories
  - **Insurance risk**: Typically unavoidable costs out of the control of providers, occurs as a result of natural activities, causes or events
  - **Performance (clinical) risk**: Avoidable costs in the control of the ACO and influenced through coordination of care, identification of care gaps and interventions
- Multi-dimensional business analytics combined with clinical intelligence maximizes performance outcome capabilities

Example of Cohort Distribution (Interventions)

- **Patient Morbidity**
- **Cost**
  - 80%
  - 15%
  - 5%
  - **Transition Interventions**
  - **Standard Risk**
  - **Moderate Risk**
  - **High Risk**

- Transition intervention programs across all cohorts
- High risk cohort is the greatest opportunity for cost savings
Example of Care Management Structure (Interventions)

Care Management “CRM Tool”

- Standard Risk (Care Gaps)
  - Outreach
  - Prevention

- Moderate Risk
  - Nurse Nav. Diabetes
  - Nurse Nav. CHF

- High Risk
  - Nurse Nav. ‘PCP/RHC’

- Transitions (Acute to Amb.)
  - Complicated Diabetes
  - ‘Exten. Clc.’
  - Nurse Nav. ‘PCP/RHC’

Initial Care Management Tools

- Clinical Disease Repository Tool
  - CDR to track process outcomes across the care continuum

- CRM Tool
  - CRM tool is used to manage the care coordination across the care management programs
  - Provide for tracking of the following:
    - Identify patient within the specific program
    - Provide care direction
    - Engage the patient
    - Track the process outcome

- Intervention Tools
Integrated Technology – Long-term Model

- Employed PCPs
- Labs
- eRx
- Hospitals
- Specialty Clinics

Patient Identity Management Tool

HIE:
- Collaborate identifies/tags Populations
- Clinical Analytic Gateway – exports criteria specific content

Care Management ‘CRM Tool’

Discharge Management
- Call Center
- Care Models/CDSS
- Patient Portal

Clinical Disease Repository

Performance Management Analytics

Where Do We Begin to Clinically Integrate Care?

- Establish a burning platform for change
- Identify programs for care coordination and quality tracking
- Physicians must lead the care coordination initiatives

The goal is to coordinate patient care and position physicians and General Hospitals for success by leveraging quality.
### CI Design Options for Physicians & General Hospital

<table>
<thead>
<tr>
<th>Physician’s Level of Collaboration</th>
<th>Hospital Organization A’s Level of Collaboration</th>
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<tbody>
<tr>
<td>High</td>
<td>High</td>
</tr>
<tr>
<td>Low</td>
<td>Low</td>
</tr>
<tr>
<td>Provider Driven Medical Home Model</td>
<td>Do Nothing</td>
</tr>
<tr>
<td>• Coordinate care within practice’s population</td>
<td></td>
</tr>
<tr>
<td>• Establish value around chronic disease outcomes</td>
<td></td>
</tr>
<tr>
<td>• Use outcomes to create value with payers</td>
<td></td>
</tr>
<tr>
<td>Clinically Integrate Care</td>
<td>Hospital Coordinated Care Model</td>
</tr>
<tr>
<td>• Tracking quality across continuum</td>
<td></td>
</tr>
<tr>
<td>• Establish a patient longitudinal record</td>
<td></td>
</tr>
<tr>
<td>• Prepare for value based contracting</td>
<td></td>
</tr>
<tr>
<td>Do Nothing</td>
<td>Focus on cost reduction</td>
</tr>
<tr>
<td>• Maintain FFS Model</td>
<td>Increase in health information technology</td>
</tr>
<tr>
<td>• Negotiate contracts under current strategy</td>
<td></td>
</tr>
<tr>
<td>• Tolerate fee schedule reductions</td>
<td></td>
</tr>
<tr>
<td>Hunting Scared</td>
<td>Connect providers to acute care setting</td>
</tr>
</tbody>
</table>

### Requirements for ACO and/or CI Physicians

- Care coordination must be physician-led
- Physicians must be represented at a decision-making level across all levels of the organization
  - From governance down to the unit level
- Metrics generated with the participation of physicians will ensure the greatest physician buy-in
- Giving physicians a stake in the outcomes of process improvement initiatives matters
Working Session: Building Accountable Care and a Clinically Integrated Network

• Assumptions
  – Opportunity to build a clinically integrated network within the community
  – Two hospital system with 100 employed physicians, most primary care but does include some specialists
  – The hospital system is self-insured with 2,500 employees and 5,600 beneficiaries
  – The community has 800 independent providers, mostly specialists
  – A second community hospital 8 miles away
    • Does not have an ACO or clinical integration strategy as of yet
  – Would like to participate in the MSSP ACO in January 2016
  – Employers in the community are asking for new clinical programs to bring down cost
Key Questions in Building the Value Proposition

CEO
- How do we more closely align with our physicians to build clinically integrated care?

CFO
- If we decrease our utilization, won’t this adversely affect our hospital bottom line?

CMO
- Where do we begin to build quality programs and measure clinical value?

Community (Affiliate) Physician
- Why should I participate in the CIN and what is the opportunity?

CIO
- Where do we start in building IT capabilities to support population health management?

Role of CEO
- Build a CI culture that is physician led
- Ensure the objectives of the CI Network, hospitals and physicians are all aligned
- The hospital system will own the CI structure, but physicians will lead the committee structures
- The approved financial investment is built around developing a collaborative approach to support population health management
- Identify physician leaders that can “lead the charge”
- Focus on the health system’s contribution to the physician value-proposition
  - Information technology around data analytics and connectivity
  - Provider financial support in the way of committee stipends for participation
Role of CFO

- Focus on the new economic drivers of value-based care
  - Reduce the “cost of care”
  - Increase domestic utilization (reducing leakage)
  - Improve care coordination between the CI network providers
  - Focus on new payer/employer contracts that drive membership
- Enroll own employees and beneficiaries into the network
  - Immediate cost savings to the hospital’s bottom line
  - Use the employee health cost savings to fund the CI investment
  - Track key financial indicators allowing for a “proof of concept” when negotiating new value-based contracts
- Begin negotiating narrow network contracts
  - Direct to employers (shared savings and partial risk arrangements)
  - Consider partnering with a commercial carrier for CI support and to drive new membership into the CIN

Role of CMO

- Build the physician network of employed group and community physicians
- Begin to slowly develop quality programs based on the following:
  - Needs of the market or value-based contract
  - Establishing quality programs with trackable measure and indicators
  - Build indicators that support physician engagement, participation and CI education
- Establish 4 committees to drive CI growth and development
  - Quality, Payer/financial, Membership, IT
- Identify criteria to build quality reporting and tracking
Community (Independent) Physician

• Value proposition for community providers:
  – Participate in a large network without becoming employed
  – Opportunity to participate in value based contracts
  – Utilize IT support of the CIN especially around connectivity and analytics
  – Leverage additional resources to help drive value in their practice

• Financial opportunity for community physicians:
  – Incentive compensation through clinical performance
  – Receive IT support around analytics
  – Improved payer contracting support through participation in a CIN

Role of CIO

• Understand the strategic direction and objectives of the CIN, and the role of information technology
• Priority 1: Build analytics capabilities
  – Identify an analytics tool based on CIN’s objectives
  – Aggregate data from available sources
  – Build an HIT strategy to support the CIN growth objectives
• Build versus buy when developing population health analytic needs
• Establish a strategy to build connectivity or interoperability with the clinically integrated network
Summary

- Healthcare is going through a transformation
- Changes in healthcare delivery and bending of the cost curve will make all of us more accountable
- Adoption and integration of information technology is a big driver of change
- New financial models will align incentives and modify behaviors
- Continue to manage the cultural change
- Aligned objectives will prepare you for accountable care

Contact

Daniel J. Marino  
President/CEO  
Health Directions, LLC  
dmarino@healthdirections.com

Meredith Duncan  
Executive Director  
Seton Health Alliance  
mdDuncan@seton.org

Health Directions, LLC  
Two Mid America Plaza, Suite 1050  
Oakbrook Terrace, IL 60181  
Phone: (312) 396-5400  
www.healthdirections.com

Seton Health Alliance  
4515 Seton Center Parkway, Suite 300  
Austin, Texas 78759  
Phone: (512) 324-3061  
www.seton.org