A Practical Approach Toward Accountable Care and Risk-Based Contracting: Design to Implementation

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Session Objectives

• Establish clinical and financial measures to enable organizational accountability.

• Plan clinically integrated programs that reduce costs and improve outcomes for specific populations.

• Combine clinical outcomes measures with claims data to track the cost of care.

• Negotiate accountable care contracts using a risk based, value purchasing or performance-based models.

• Align physician and hospital objectives to promote value-based coordinated care initiatives.
The Healthcare Reality of Today

- Healthcare costs continue to rise placing pressures on patients, employers and healthcare providers
- Drivers of healthcare costs:
  - Technologic Advances
  - Prescription Drugs
  - Aging Population
  - Administrative Costs - 7% of total spending
- Fragmented care delivery models
- Misaligned incentives
  - Strong history of encounter-based reimbursement

Impact on Physicians & Hospital

- Volume drives financial success
  - Minimal alignment service related outcomes
- Primary care physicians unable to effectively manage chronically ill patients
- Minimal attention given to clinical outcomes, due to difficulty in measuring the patient’s “full cycle of care”
- Under capitalized information technology infrastructure
  - Strong pressures to connect care
- The value of data continues to rise
Shift from Pay for Service to Pay for Value

- Radical movement from speed and volume, to performance and care coordination
  - Quality matters
  - Providers held “accountable”
  - Managing Costs
    o Total cost of care
    o Cost of providing care
  - Clinically integrated care
  - Non-traditional patient engagement approaches
- Continued pressure to connect systems and exchange data

Clinical Integration and ACOs

4 Areas of Focus

- Quality Program and Measures
- Payer Strategy
- Provider Membership (Hospital, Physicians, Post-Acute, etc.)
- Health Information Technology
Data Elements that Drive Value

**Volume Measures (Claims)**
- Claims data (CPT, ICD-9)
- CPT-II data
- Encounters by chronic disease ICD-9
- Encounters by place of service, provider
- wRVUs
- Collection and cost per RVU
- Admissions and re-admissions
- Referral tracking

**Quality Outcomes (Clinical)**
- Chronic disease lab outcomes
- Clinical measurements (BMI)
- Clinical screenings (i.e. smoking, fall risk, depression)
- Identification of screening plans (smoking cessation, fall risk plan)
- Wellness/prevention (flu vaccines, pneumococcal)
- Admissions and re-admissions
- Generic versus name brand med utilization

Measure Selection Process Approach

- Which pay-for-performance programs does the organization currently participate? (i.e. MSSP, Bridges to Excellence, BCBS)
- What measures will serve to improve the priorities of the organization?
- Are the measures relevant to the stakeholders? What are the expectations among the different stakeholders?
- What data sources are currently available? Will the measure be able to be compared?

Measures selected must be ones that can be measured and compared (consistent with national measures)...and demonstrate VALUE. For CI, the FTC expects the same evidence-based protocols.
Domains and Measures

- **Structure**: capacity to provide high-quality healthcare
  - Supported by other clinical quality measure domains
- **Process**: healthcare-related activity performed for, on behalf of, or by a patient
  - Supported by evidence that the clinical process has led to improved outcomes
- **Outcome**: a health state of a patient resulting from healthcare
  - Detect the impact of one or more clinical interventions
  - Attributable to antecedent healthcare and should include provisions for risk-adjustment

Source: [www.qualitymeasures.ahrq.gov](http://www.qualitymeasures.ahrq.gov)
Domains & Measures: Definitions (cont.)

- **Access**: attainment of timely and appropriate healthcare by patients
  - Supported by evidence that an association exists between the measure and the outcomes of (or satisfaction with) care

- **Patient Experience**: patient's report of observations of (and participation in) healthcare, or assessment of any resulting change in their health
  - Supported by evidence that an association exists between the measure and patients' values and preferences, or one of the other clinical quality domains

Source: [www.qualitymeasures.ahrq.gov](http://www.qualitymeasures.ahrq.gov)

Comprehensive Diabetic Care: Sample Measures by Domain

- **Structure**
  - Percentage of providers using CPOE (labs)

- **Process**
  - Percentage of diabetics with HbA1c Testing

- **Outcomes**
  - Percentage of diabetics with HbA1c >9.0%

- **Access**
  - Response time for clinical advice during office hours

- **Patient Experience**
  - CAHPS Patient-Centered Medical Home (PCMH) survey results: Communication score
Comprehensive Diabetic Care: Measure Crosswalk Table

<table>
<thead>
<tr>
<th>Measure</th>
<th>HEDIS</th>
<th>NQF</th>
<th>PQRS</th>
<th>PCMH</th>
<th>ACO</th>
<th>MU</th>
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<tbody>
<tr>
<td>HbA1c</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>LDL-C</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Medical attention for nephropathy</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Influenza Vaccination</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Pneumococcal Vaccination</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Eye exam</td>
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<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Tobacco use</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tobacco cessation</td>
<td></td>
<td></td>
<td></td>
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<td>X</td>
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</table>

Clinical integration has emerged as the driving force behind value-based performance.

Connecting physicians, hospital, post-acute and the community to better manage cost and achieve higher quality outcomes.

Leverage network quality performance and cost management to create value-based care.

Building the Clinically Integrated Network
Clinical Integration and Value-Based Reimbursement

- Commercial Payers participating in development of collaborative care management
- CMS (ACO) and Commercial Payers based on meeting performance targets
- Upside/Downside Risk
- Shared Savings with PMPM Care Management Fee
- Fee-For-Service Plus Shared Savings

Summary of ACOs

Accountable Care Organization:
A legal entity allowing an organization to receive and distribute payments from shared savings to participating providers of services via the Medicare Shared Savings Program

- ACO professionals in group practices
  - Networks of individual practices of ACO professionals
  - Partnerships or joint venture arrangements between hospitals and ACO professionals
  - Hospitals employing ACO professionals (providers)
- Have a mechanism for shared governance
Components of an ACO Financial Model

ACO Revenues:
Shared Savings from CMS

ACO Expenses:

Initial Investment:
- Legal
- Consulting
- IT Infrastructure

Operating Expenses:
- Clinical programs
  - Transition, outreach
- Staffing
  - Nurse navigator
  - Quality informatics
- Administrative
- IT Connectivity, analytics, performance measurement, care gap reports

Define Beneficiaries
Performance Scores
Cost Utilization
Net Savings

Making the Value-Based Economics Work

- Breakdown the beneficiaries into risk cohorts
  - Cost utilization based on claims data
- Identify “High Risk” beneficiaries with multiple comorbidities
  - Highest cost contributors
- Manage the hospital transitions
The Big Question Asked by Hospital CFOs

“If we reduce inpatient services which drive a lot of our system’s revenues, won’t this reduce our overall bottom line? What’s the incentive?”

Reasons Hospitals Want to Participate

- Scalable learning lab for future value-based world
  - Nominal absolute financial impact to the hospital
- Opportunity to integrate/align with key physicians without acquiring their practices
- “Pull Through” effect of incentive design
  - Increased “in network” referrals from all payers
  - Collaboration on hospital cost & safety initiatives
    Examples: readmissions, physician preference items, etc.
- Opportunities to dynamically structure hospital shared savings portion to ensure ROI
- Preempts physicians from aligning with competitors
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 Hospitals for success by leveraging quality.
### Options for Physicians & Organizations

<table>
<thead>
<tr>
<th>Physician’s Level of Collaboration</th>
<th>Organization’s Level of Collaboration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>Low</td>
</tr>
<tr>
<td>High</td>
<td>High</td>
</tr>
</tbody>
</table>

#### Create Provider-Driven Medical Home Model
- Coordinate care within practice’s population
- Establish value around chronic disease outcomes
- Use outcomes to create value with payers

#### Do Nothing
- Maintain FFS Model
- Negotiate contracts under current strategy
- Tolerate fee schedule reductions

#### Clinically Integrate Care
- Track quality across continuum
- Establish a patient longitudinal record
- Prepare for value-based contracting

#### Develop Hospital Coordinated Care Model
- Focus on cost reduction
- Invest in health information technology
- Connect providers to acute care setting

### Moving an Organization Forward

- Build the Infrastructure and Make the Case for Change
- Develop Primary Care Participation First
- Critical Features/Ground Rules
  - Physician defined measures
  - Meaningful incentives
  - Timely feedback
  - Embed in system governance
**Physician Committee Participation**

- Hourly rate for participation
- System Support for Pay for Performance
- IT presence in the committee, especially during design process
- Audit process defined

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**Cultural Transformation with CI**

- Develop Primary Care Initiatives First
  - Coincide with Medical Home, ACO, Meaningful Use, PQRS/GPRO, Wellmark
- Expand specialty specific measures and measures of care coordination in a system
- Develop opportunity for unifying record
Develop System Quality and Governance

• Predominantly primary care
• Coincides with ACO governance
• Drives organizational strategic plan initiatives
• Key driver of system coordination of care measures and central discussion for value-based purchasing

Continuous Improvement Program

• Lean/Six Sigma
• Team involved in identifying weaker areas
• Improvement projects measure and modify the process
How do Physicians Get Paid?

• As the clinically integrated network begins to develop, the CI entity negotiates value-based contracts with payers

• “Incentive Only” Contracts vs. “Full” Contracts
  – “Full” Contracts Include Base FFS Rates
  – Group Contract
  – Shared Savings vs. Performance

• Base Rates – Physicians continue to bill and collect from insurance company under group contract rates & terms

• Incentives paid to CI entity, then distributed per program measures, weighting and physician performance

Questions that Guide Clinical Integration

• How can the Governance structure be organized to successfully lead the process?

• What are the key cultural changes that need to be addressed?

• How can the Clinical Integration initiative be coordinated with other health system priorities?

• What technology is required to build Clinical Integration?

• Why should community physicians participate in Clinical Integration (what’s the value)?
Distributing the Earned Savings

- Must be large enough to gain attention
- Must incorporate incentives to reward behavior
- Establish individual incentives based on individual criteria
- Establish a residual fund for future investments, future years incentives or specially bonuses

Example of Distribution Approach

- ACO Shared Savings Pool ($1.00)
- Residual Fund ($0.05) - Maintain within ACO
- Hospital, Post Acute, Others ($0.25)
- Physician Incentive ($0.70)
- Individual Distribution
  - Individual Performance
ACO Key Performance Indicators

<table>
<thead>
<tr>
<th>Intervention Process Measures</th>
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<tbody>
<tr>
<td>Number of patients high-risk intervention</td>
</tr>
<tr>
<td>Number of patients moderate-risk intervention</td>
</tr>
<tr>
<td>Number of patients transitioned out of member hospitals</td>
</tr>
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<table>
<thead>
<tr>
<th>Utilization Measures</th>
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</thead>
<tbody>
<tr>
<td>IP admits/1000</td>
</tr>
<tr>
<td>IP days/1000</td>
</tr>
<tr>
<td>ED visits/1000</td>
</tr>
<tr>
<td>ED to inpatient admit/1000</td>
</tr>
<tr>
<td>SNF Days/1000</td>
</tr>
<tr>
<td>Average LOS</td>
</tr>
<tr>
<td>30 Day Readmissions - HR Intervention Population</td>
</tr>
<tr>
<td>30 Day Readmissions - MR Intervention Population</td>
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<tr>
<td>30 Day Readmissions - Transition Population</td>
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<table>
<thead>
<tr>
<th>Cost Measures</th>
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<tbody>
<tr>
<td>Medical PMPM</td>
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<tr>
<td>IP PMPM</td>
</tr>
<tr>
<td>Office PMPM</td>
</tr>
<tr>
<td>Outpatient Hospital PMPM</td>
</tr>
<tr>
<td>SNF PMPM</td>
</tr>
<tr>
<td>ED PMPM</td>
</tr>
</tbody>
</table>

Payer Contracting & Pay for Performance Strategy

- Engage payers in contract/program discussion
- Determine the economic and medical impact
  - Engage purchasers early to determine ‘cost drivers’
    - Self-insured large employers
    - Health plans
  - Build CI around these drivers
- Create a partnership with provider community
- Identify or determine other health plan incentives
  - (i.e., IPRO, PCMH Level 1-3)
Contracting

<table>
<thead>
<tr>
<th>Insurance Risk</th>
<th>Performance Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whether an individual gets ill</td>
<td>Ability to effectively treat illness in a cost effective way</td>
</tr>
<tr>
<td>Providers should not be expected to accept insurance risk</td>
<td>Providers should be responsible for their performance</td>
</tr>
</tbody>
</table>

• Accountable care transfers performance risk to providers
• There is no absolute dividing line between insurance risk and performance risk
• Mechanisms must be in place to define and monitor the new risks the accountable care organization is assuming

Negotiating with Health Plans

• Approach all major plans in your market
• Consider risk and fee-for-service products
• Performance based reimbursement should be composed of a base rate plus incentive compensation
• Use same measures across all payers
• Incorporate common procedures at the practice level
• Reduced hospital stays have value, leverage the concept!
Reimbursement Models

- ACO models are primarily shared savings, performance based or comprehensive care (global payment)
- Managing “Risk” is a driving force behind ACO reimbursement models

Example of Payer Reimbursement

3 Models:
1. Panel fee (partial Capitation)
2. FFS plus
3. Performance based

Assumption: $5,000 total reimbursement payment opportunity

<table>
<thead>
<tr>
<th>Model</th>
<th>Based Rate</th>
<th>Tier 1</th>
<th>Tier 2</th>
<th>Tier 3</th>
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</thead>
<tbody>
<tr>
<td>Panel Fee</td>
<td>$1,667 (1/3)</td>
<td>100%</td>
<td>1/2</td>
<td>1/3</td>
</tr>
<tr>
<td>FFS plus</td>
<td>$2,500</td>
<td>(½) Shared Savings Bonus</td>
<td>¾</td>
<td>½</td>
</tr>
<tr>
<td>Performance</td>
<td>$833 (1/6)</td>
<td>125%</td>
<td>½</td>
<td>¼</td>
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</table>
What’s Required to Manage the Risk

1. Data Aggregation/Management across various sources including EMR, Lab, RX, Financial (claims data)

2. Analytics and Modeling – stratification of patient information, population, risk adjustments, measurement and predictive modeling

3. Reporting and Tools – disease registry (clinical data repository), electronic exchange, CRM tool

4. Transformation Strategies – interventions at point of care, population management, CDSS, provider alerts

Our Healthcare Climate is Changing

…and we all will be affected
Summary

- Changes in healthcare delivery and bending of the cost curve will make all of us more accountable
- Data continues to drive value
- Building measures by domains will support your library of measures
- New financial models will align incentives and modify behaviors
- Aligned objectives will prepare you for accountable care
- Lastly, don’t forget to manage the cultural change

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