Yesterday You Said Tomorrow

Driving Value through Delivery System Innovation and Charting a Course for Value-Based Care: Insights from the Design, Build and Run Phases of an ACO’s Journey

July 27, 2015
Meeting Objectives – Establishing the Context

1. Why you keep hearing CHANGE!

2. What am I supposed to CHANGE!

3. How do we effect this CHANGE!

4. The dog caught the car. Now what!

*Please note that the views expressed by the conference speakers do not necessarily reflect the views of the American Hospital Association and Health Forum.*
Change is NOT the Result of This...
It is because....

**Healthcare Spending per capita vs. Average Life Expectancy Among OECD Countries**

Source: OECD

USA, Inc. Income Statement Drilldown
....and because...

<table>
<thead>
<tr>
<th>2007 Health Indicators</th>
<th>USA</th>
<th>OECD Median</th>
<th>USA Rank  (1 = Best, 30= worst) Red is below Avg</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obesity (% of total population)</td>
<td>34</td>
<td>15</td>
<td>30</td>
</tr>
<tr>
<td>Infant Mortality (per 1,000 live births)</td>
<td>7</td>
<td>4</td>
<td>27</td>
</tr>
<tr>
<td>Medical Resources available (per 1,000 population)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Hospital Beds</td>
<td>3</td>
<td>6</td>
<td>25</td>
</tr>
<tr>
<td>Practicing Physicians</td>
<td>2</td>
<td>3</td>
<td>22</td>
</tr>
<tr>
<td>Doctors’ consultations per Year</td>
<td>4</td>
<td>6</td>
<td>19</td>
</tr>
<tr>
<td>MRI Machines* (per million population)</td>
<td>26</td>
<td>9</td>
<td>1</td>
</tr>
<tr>
<td>Cause of death (per 100,000 population)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart Attack</td>
<td>216</td>
<td>178</td>
<td>22</td>
</tr>
<tr>
<td>Respiratory Diseases</td>
<td>60</td>
<td>45</td>
<td>21</td>
</tr>
<tr>
<td>Diabetes</td>
<td>20</td>
<td>12</td>
<td>20</td>
</tr>
<tr>
<td>Cancer</td>
<td>158</td>
<td>159</td>
<td>14</td>
</tr>
<tr>
<td>Stroke</td>
<td>33</td>
<td>45</td>
<td>8</td>
</tr>
</tbody>
</table>

Source: OECD; USA, Inc. Income Statement Drill Down; www.KPCB.com
…and not to mention

Retrieved from: http://www.annfammed.org/content/10/2/156.full.pdf
And so far… Many Responses

Rapid Growth of ACOs Year Over Year

<table>
<thead>
<tr>
<th>Year</th>
<th># of Payors Participating in ACOs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 2011</td>
<td>64</td>
</tr>
<tr>
<td>Q1 2012</td>
<td>174</td>
</tr>
<tr>
<td>Q1 2013</td>
<td>447</td>
</tr>
<tr>
<td>Q1 2014</td>
<td>621</td>
</tr>
<tr>
<td>Q1 2015</td>
<td>744</td>
</tr>
</tbody>
</table>

# of Lives (in Millions) Covered in ACOs

<table>
<thead>
<tr>
<th>Year</th>
<th># of Lives (in Millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>5.6</td>
</tr>
<tr>
<td>2012</td>
<td>14.6</td>
</tr>
<tr>
<td>2013</td>
<td>19.2</td>
</tr>
<tr>
<td>2014</td>
<td>23.5</td>
</tr>
</tbody>
</table>

1) Leavitt Partners Center for Accountable Care Intelligence, 2015
But Haven’t We Seen This Movie Before?

1990’s

Lack of Shared Incentives
Lack of Physician Voice
Fragmented Structure

Limiting access dictated margin success.

Today

Aligned Incentives
Physician-led and Physician-driven Effort
Coordination Powered by Technology

Today, quality gates help determine margin

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1) Deloitte Center for Health Solutions. “Physician-hospital employment: This time it’s different.” 2013.
What is ‘Value-Based’ or ‘Accountable’ Care?

Value-Based Care = (Access + Quality = Outcomes)

Cost

Financial Opportunity & Incentive Alignment

VALUE-BASED DELIVERY SPECTRUM

P4P | PCMH | CLINICAL INTEGRATION | SHARED SAVINGS | BUNDLED PAYMENTS | SHARED RISK | CAPITATION FULL RISK | PROVIDER-SPONSORED HEALTH PLANS
Why Value-Based Care Makes Sense

- Strengthen relationships with physicians
- Protect or enhance market share/position
- Increased control of network usage
- Financially benefit from bending cost curve
- Not as financially risky as it seems
- Refocus mission to population management from acute episodes
- Advance / accelerate quality initiatives
Physician Alignment: Required in the Transition To Value-based Care

**Key Market Forces**
- **Consolidation and integration**
- **Physician alignment**
- **Innovative care delivery**
- **Value-based care maturity**

**Recent Trends**
- Regional networks, increasing competition
- Smaller systems and physicians developing their own networks; partnering with existing networks
- Physician groups leading effort on clinical quality, cost efficiencies, and access
- Physician network performance a leading strategy; large networks begin to cull lower performers
- Disruptive innovators are entrenched
- Creative solutions to reach patients better and improve quality and lower cost of care
- Networks offering health plans, direct to employer contracts and/or accepting risk
- Payors looking to expand plans tied to ACOs, increase narrow networks and reduce FFS reimbursements

**Strategic Implications for Health Systems and their Physicians**

1. Physician integration will provide more opportunities for surviving in the value-based world
2. Option(s) should provide differentiation and competitive advantage
3. Potential partners must address current needs and be aligned on future goals
4. Formal integration will serve as the vehicle to align payer contracts with care delivery models
Value-based Payments Will Double by 2018, Creating a $300 Billion Payment Shift

- Payors are quickly shifting from fee-for-service payment arrangements
- Multiple value-based payment models are being deployed, from capitation to pay-for-performance
- Provider organizations’ ability to develop diversified revenue sources, including various value-based terms, is key to long-term sustainability

Commercial payers will move away from FFS only contracts over next 5 years

(Percent of Overall Payment Mix)

<table>
<thead>
<tr>
<th>Payment Model</th>
<th>2014</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>FFS</td>
<td>30%</td>
<td>25%</td>
</tr>
<tr>
<td>P4P</td>
<td>10%</td>
<td>15%</td>
</tr>
<tr>
<td>Bundled</td>
<td>5%</td>
<td>10%</td>
</tr>
<tr>
<td>Global Payment</td>
<td>5%</td>
<td>8%</td>
</tr>
<tr>
<td>Capitation</td>
<td>20%</td>
<td>25%</td>
</tr>
<tr>
<td>Other</td>
<td>15%</td>
<td>20%</td>
</tr>
</tbody>
</table>

24% decrease in FFS only


Medicare will increase use of alternative payment models between 2014-2018

(Percent of Overall Payment Mix)

<table>
<thead>
<tr>
<th>Payment Model</th>
<th>2014</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>FFS only</td>
<td>30%</td>
<td>24%</td>
</tr>
<tr>
<td>FFS Linked to Quality</td>
<td>10%</td>
<td>15%</td>
</tr>
<tr>
<td>Alternative Payment Models</td>
<td>5%</td>
<td>10%</td>
</tr>
</tbody>
</table>

30% ($150B) increase in alternative payments

Client Profile: Care New England

963 licensed beds, 80 NICU, 136 bassinets
Total Revenue (2013) $893m

- Psychiatric care
- General acute care
- Women’s and infant health
- Skilled care, rehabilitation, hospice and palliative care
- General acute care
- Acquired in September 2013
Integra Today

Care New England Hospitals and Employed Physicians

Rhode Island Primary Care - ~120 physicians
Additional Physicians - 65

Engaged w/Valence Health spring 2014
Formalized ACO 5/2014
ACO granted 11/2014

Currently over 45,000 Covered Lives

BCBS Medicare Advantage and Bundles
Medicare Shared Savings Program
Self-funded employee plan

Valence Health
Community Care Network
Sample Design Process and Outcome

**Current State**
- Self funded for employee health plan
- You are already in the game: Employee health, under or no insurance
- New CEO declared “We will be a certified ACO”

**Assessment**
- Internal – gap analysis with MSSP Manual, ACO Workbook
- External – market assessment
- Assess care delivery infrastructure - care management, care continuum
- IT – accumulate, access and act upon the data you generate and have access to
- Integrated structure needed to achieve goals
- Willingness to invest
- External partner accountabilities

**Strategic Roadmap and Build**
- Organizational culture and leadership
- Physician integration and collaboration
- Level of risk progression (when is it too late?)
- Technology – population health, analytics, and care management
- Community appetite to partner (payors, employers, physicians)
- Human resources – executives, care management, finance, analytics
- Capital resources – technology, overhead
- Access – Right care, right place, right time

**Areas of Focus**
Sample Design Process and Outcome

• Enter risk arrangements ahead of preparedness
  o waiting until you are “ready” will be too late
    – https://www.youtube.com/watch?v=L2zqTYgcpg
  o Create the burning platform
  o Don’t earn money just for payers
  o Likely need to buffer the docs

• The tipping point – when are you ready to take risk?
  o Not quantitative: It will not be based on a percent of revenue or number of lives
  o You will see the tipping point from:
    ✓ Your leadership – when they state it is the new direction
    ✓ Mindset changes; vision modified
    ✓ Communication occurs from and among leadership
Build – Where Can You Start? Where Should I Focus?

- Helpful material - ACO handbook (pdf attached)
- Importance of work committees: Buy in, foundation for future
  - Governance, leadership
  - Clinical (Care Management, Care Continuum)
- Care management, care management, care management
  - Must include inpatient
  - We thought we were doing it
- The population pareto
  - Rising risk – they will become high risk
  - Prevent your population from shifting to the left
  - Identify and close gaps in care

<table>
<thead>
<tr>
<th>The Population / Cost Pareto</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hi Risk</td>
</tr>
<tr>
<td>Population</td>
</tr>
<tr>
<td>TCOC $</td>
</tr>
<tr>
<td>Condition Example</td>
</tr>
</tbody>
</table>
8 Key Dimensions Determine Value-based Readiness

Least Influence

Market Intrinsic
- MSA Market Population
- Population Density of MSA
- MSA Payer Mix
- Population Trends
- MSA Utilization Rates

Value Prop
- Primary Care
- Specialist
- Hospital
- Payer

Market Competitive
- Value-based Competitors
- PCP Control
- Market Share Differentiable Service Lines
- MD Reimbursement
- Payer Relations

Org Capacity
- MD-Hospital Collaboration
- Financial Position and Strength
- Claims-Based Performance Data
- Cross-Continuum Services
- Executive Alignment
- Bandwidth

Physician Alignment
- Hospital – Private MD Relations
- Economic Alignment
- Clinical Alignment
- Urgency for Change
- P4P Experience

Collaboration Culture
- PCP – Specialty Relations
- System-ness
- Referral Management
- Forums

Care Continuum
- Service Distribution
- VNA & SNF
- PCMH
- Disease Mgt
- Care Coordination
- Pharmacy
- Patient Registry
- Patient Attribution

Greatest Influence

Technology
- EMR
- HIE
- Analytics
- Portal
- Pop. Health
- Patient Attribution

Valence Health
Integra
Community Care Network

LEADERSHIP SUMMIT
It Doesn’t All Have to Happen at Once

<table>
<thead>
<tr>
<th>Program Focus</th>
<th>Crawl</th>
<th>Walk</th>
<th>Run</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Build Program Foundation</td>
<td>• Refine Metrics</td>
<td>• Focused CM Programs</td>
<td></td>
</tr>
<tr>
<td>• Obtain the Data</td>
<td>• Educate Physicians</td>
<td>• Hold Physicians Accountable</td>
<td></td>
</tr>
<tr>
<td>• Get Payer Buy In</td>
<td>• Publish Data</td>
<td>• Assume Risk</td>
<td></td>
</tr>
<tr>
<td>• Participation Measures</td>
<td>• Process Measures</td>
<td>• Outcome Measures</td>
<td></td>
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<table>
<thead>
<tr>
<th>Tactics</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>UM/CM/Referrals:</strong></td>
<td><strong>DM/Populations:</strong></td>
<td><strong>Enhanced capabilities:</strong></td>
</tr>
<tr>
<td>• Basic “blocking and tackling”</td>
<td>• High cost</td>
<td>• PCMH, Navigators/Coach</td>
</tr>
<tr>
<td>• Adopt care guidelines, measure and share data</td>
<td>• High frequency</td>
<td>• Care Continuum/Transitions</td>
</tr>
<tr>
<td></td>
<td>• High risk</td>
<td>• Practice Pattern Changes</td>
</tr>
<tr>
<td></td>
<td>• Quality, utilization &amp; financial reporting</td>
<td>• Focused PI</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Network/Incentive Focus</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Participation -&gt; Process</td>
<td>• Process -&gt; Outcomes</td>
<td>• Outcomes -&gt; VALUE</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient Focus</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Educate</td>
<td>• Engage</td>
<td>• Empower</td>
</tr>
</tbody>
</table>
Criteria to Select Value-Based Options

- Do you need a laboratory to learn how to manage populations
- Right amount of Business
- Align incentives of health system to physicians and payors
- Network Development
- Improve Value
- Right amount of risk at the right time
- Market Willingness
- Market Shift

Timing of Risk Assumption vs. Economic Opportunity

- Early move to risk
- Late move to risk
- Time

Implications of Risk Mix

- P4p / Full Risk Bearing / ACO
- Fee-for-Service
Three Step Process to Evaluate Market Opportunities

Key Components of Market Intelligence Development

1. External Data Sources
   - Identify value-based trends, key competitors, and employer activity

2. Data Request
   - Pinpoint key opportunities for integration

3. Interviews with Key Stakeholders
   - Discern payor value-drivers and contracting trends

Market Profile and Competitive Position

Physician Landscape

Payor Assessment

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Valence Health

LEADERSHIP SUMMIT

Integra Community Care Network
Assessing Value: Questions to Consider

1. Considering your peers, how would you rate the following on a scale of 1-5 (5 being the highest)?
   a) Awareness of national changes in the healthcare industry (e.g. recent SGR fix bill, CMS and Commercial payer VBC commitments)
   b) Interest in value-based care (e.g. ACOs, CINs, bundled payments)
   c) Sense of urgency toward adopting value-based models
   d) Interest in greater collaboration and coordination of patient care across settings (e.g. ED, inpatient, outpatient, post-acute)
   e) Interest in easy access to data and reports to track performance on key metrics

2. Discuss openly thoughts on the current value-based movement nationally and for your market. Have you seen any impact financially? Administratively?

3. What are your hesitations (if any) about becoming more integrated with your local health system?

4. Can you convince a purchaser of your service and its value to patients, employers?
Multiple Stakeholders

**Integrated Structure**
- Physicians – Independent and Employed
- Acute and sub-acute providers

**Payors**
- Commercial
- CMS
- Narrow Networks

**Health Systems and Providers**
- Stand-alone Hospital
- Multi-hospital System

**Employers**
- Employers
- Employees
- Dependents
Clinical Integration is the Foundation for Building Critical Risk Capabilities

Network Development

IT Infrastructure and Capability

Organizational Structure & Planning

Cross-continuum Coordination

Analytics

Collaboration Platform
Establish a Foundation for Successful Network Integration

Critical Success Factors

• **Applied Strategy**
  - Each market is unique
  - Straw models
  - Focused strategy to address “Triple Aim”

• **Physician Engagement, Alignment**
  - Build value proposition early
  - Communicate often
  - Design simply
  - Respect work loads

• **Project Management**
  - You are leading transformation
  - Identify multiple stakeholders
  - Reach out to each stakeholder group
  - Communicate often and regularly
  - Will require constant and full time attention

• **Communication**
  - Use quantifiable data, information: knowledge development
  - Understand what channels work in your audience

• **Collaboration**
  - Work with payers; collectively build value propositions
  - Identify value in sharing data
  - Be able to demonstrate the win-wins

• **Data and Analytics**
  - Start right away
  - Collaborate with payers
  - Accumulate, Access, Action
Key components of developing payor contracting strategy include:

- Agree on levels of risk to pursue
- Formulate preliminary payor value propositions
- Confirm year one quality measures
- Identify target payor partners
- Define straw model for three-year contracting model
- Analyze physician fee schedules in the market
- Engage in initial conversations with payers
- Learning model: Crawl, walk, run
Develop Payor Strategy Early: Focuses Payor Conversations and Shapes Network Development

Attributed population size and risk assumption increases over time

<table>
<thead>
<tr>
<th>Year 1: P4P and Shared Savings</th>
<th>Year 2: Shared Risk with Corridors</th>
<th>Year 3: Shared Risk with Wider Corridors</th>
</tr>
</thead>
</table>
| • Negotiate 3-year plan for **metrics and incentives** | • 5% corridor  
  • 50/50 risk sharing **inside corridor**  
  • Payor **assumes all risk outside corridor** | • 7.5% corridor  
  • 50/50 risk sharing inside corridor  
  • Payor assumes all risk outside corridor |
| • Re-distribute funds flow to **enhance PCP reimbursement** while maintaining cost neutrality | • Internal gain sharing: share gains only, with **performance-based** incentives  
  • Re-calibrate internal funds flow and incentive design to **ensure network integrity** | • Internal risk sharing: share gains with performance-based incentives and **share portion of losses** |
| • Gain share with payers and **tie to quality** performance | | • Evaluate network performance; cull participants unwilling/unable to demonstrate value |
| • Learn what **physician alignment** configuration works best | | |
| • Develop data and reporting structures in “up-side” only model | | |

• Negotiate 3-year plan for **metrics and incentives**  
• Re-distribute funds flow to **enhance PCP reimbursement** while maintaining cost neutrality  
• Gain share with payers and **tie to quality** performance  
• Learn what **physician alignment** configuration works best  
• Develop data and reporting structures in “up-side” only model

**Illustrative**

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**Valence Health**

Leadership Summit

**Integra**

Community Care Network
### Is it Semantics?

<table>
<thead>
<tr>
<th>Case Management</th>
<th>Care Coordination</th>
<th>Population Health Management</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Objective</strong></td>
<td>Optimize care plans; maximize function</td>
<td>Facilitate access/ deliver value</td>
</tr>
<tr>
<td><strong>Target Population</strong></td>
<td>High-cost/ high-use patients</td>
<td>Medium and High-risk populations</td>
</tr>
<tr>
<td><strong>Tactical Approach</strong></td>
<td>Maximize benefits, leverage alternative options</td>
<td>Problem solving and process improvement</td>
</tr>
<tr>
<td><strong>Mindset</strong></td>
<td>Patient focused and on-going problem solving</td>
<td>Longitudinal</td>
</tr>
<tr>
<td><strong>Setting</strong></td>
<td>Within a single organization providing medical care (ACO, CIN, IP/OP, PHO, etc.)</td>
<td>Deployed to practices</td>
</tr>
</tbody>
</table>

Note: Adapted from Colorado Department of Public Health
A New World Order: Leveraging Drivers from Purchasers

State Government
- MCOs
- Requiring Networks
- Risk off-loading

Integrated Network:
- Value achieved
- Incentives aligned
- Quality improved
- Cost managed

Health System Employees
- Incentives
- Benefit designs
- Provider education

CMS:
- CMMI Bundles
- MSSP ACO
- Medicare Advantage

Commercial:
- Partnered Payer
- Claims and data sharing
### Tactical Plan and Lessons Learned

#### Initiation

**Alignment:**
- Engage the physicians – independent and employed
- Executive “buy-in” and subject matter expertise support

**Capital Investments:**
- Expect an initial investment of 1 to 2 million dollars
- Budget for technology investment

**Governance:**
- Create legal entity
- Create Board and accountabilities

#### Design

- Create and Engage Design Committees
- Operating and Participation Agreements
- Prioritize Payor Opportunities and Strategy
- Develop “CI” Product

#### Lessons Learned

**Lessons Learned:**
- Education/buy-in takes 1-2 years
- Don’t underinvest in capabilities
- Focus on primary care alignment
- Diversify physician value propositions
- Develop value-base payor strategy early and aggressively
- Focus on your “product” – improved quality and reduced cost
What’s next

• Recruit dedicated physician leadership
• Build-out network functional staff to support operations
• Implement physician connectivity and data collection and operationalize portal
• Quality Committee to complete designing patient centered medical home care model and quality cost metrics
• Finance Committee to complete payer contracting strategy and begin value-based contract negotiations
• Network Committee continue to grow physician network targeting an additional “x” physicians for 2015
CMS: How Will They Lead in the Years Ahead

CMMI
- “The Vig”: House Money
- Changing Rules
- A Gift

MSSP
- Two Bright Lines
  - Covered lives – 5,000
  - 75% Board Participation
- Benefit plans trumps risk

Medicare Advantage
- Watch the top line
  - Percent of Premium
- Risk Adjustment Factors and Coding
  - Know what you don’t know
  - Fix it. Now.

And don’t forget implications from the SGR Fix

- New Components will require new leadership
  - Physician
  - Organizational
  - Clinical
  - Financial
  - Strategic

- Consistency and clarity of message:
  - Why are we doing this
  - What does it mean for you

And don’t forget implications from the SGR Fix
The Future

• Commitment – to Commercial
• Next Generation ACO
• Medicaid (3 year grant submitted)
• Do we need “multiple ACOs”? 
• Are we going back to the future?
  • Health Advantage
  • AHA Presentation
Society for Healthcare Planning and Marketing of the AHA

Boston, MA

Securing And Successfully Managing Covered Lives Contracts In A PHO

May 8, 1995
1995 – Our First ACO
Yesterday You Said Tomorrow

...your market is waiting no more
If You Have Any Questions

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