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ACOs in Action

Becker's Hospital Review Annual Meeting
May 18, 2012

Andrew Ziskind, MD, Managing Director, Clinical Solutions Leader
Tim Ogonoski, Managing Director, Physician Services

Overview

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- How reform is changing the healthcare and payment landscape
- What we're seeing in the market: Emerging hospital and physician responses in the ACO environment
- Challenges facing new ACO's
- Managing the timing of change

National Health Expenditures and Their Share of Gross Domestic Product, 1960-2009

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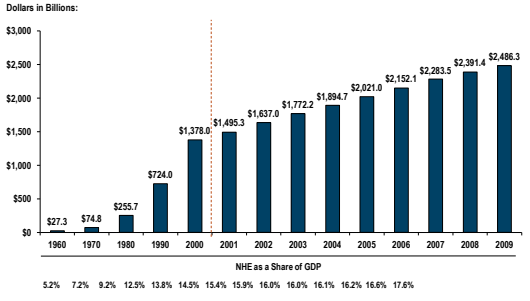
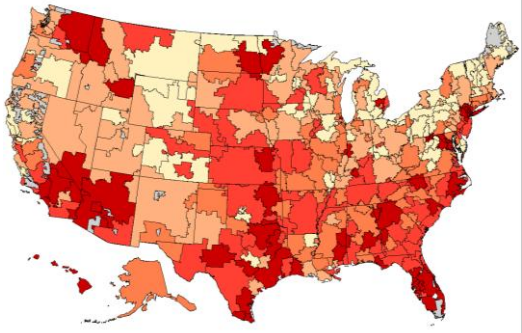


Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, at http://www.cms.hhs.gov/NationalHealthExpendData/ (see Historical; NHE summary including share of GDP, CY 1960-2009; file nhegdp09.zip) via The Henry J. Kaiser Foundation http://facts.kff.org/chart.aspx?ch=302

Geographic Variation in Screening for Prostate Cancer



Four Primary Market Forces are Driving Payment and Delivery Reform

Care Delivery and Payment Reform

A fundamental shift in how we deliver and pay for healthcare services

Element of Change	TODAY	FUTURE
Health Care Focus	Sick Care	Wellness and Prevention
Care Management	Manage utilization and cost within a care setting	Manage on-going health (& Optimize Care Episodes)
Delivery Models	Fragmented / Silos	Care Continuum & Coordination (Right Care, Right Place, Right Time)
Care Setting	In office / hospital / person	Home, e-health, m-health
Physician Platform	Solo practitioners	Multi-specialty, integrated
Clinical Systems/EMR	Transactional	Interoperable, HIE
Quality Measures	Process-focused, Individual	Outcomes-focused, Population based
Reimbursement	Fee-for-service	Value-Based (Outcomes, Utilization, Total Cost)
Financial Incentives	Do more, make more	Perform better, make more
Financial Performance	Margin per service, procedure, etc. (bed, doc, etc.)	Margin per life

Payment Models are Evolving

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Traditional FFS	FFS Shared Savings	Episodic Bundling	Global Payment	Traditional Capitation
Provider(s) paid on the basis of volume of services • Provider bills separately for each service performed • Currently the most commonly used payment system by providers	Group of providers paid on a FFS basis who deliver care against a preset budget to determine shared savings • Primary payment mechanism for Medicare Shared Savings program • Considered a "stepping stone" to more widespread use of bundled and global payments	Bundled payment for some or all services delivered to a patient for an episode of care for a specific condition over a defined period • Payment usually less than sum of FFS parts for that episode • Utilized for care "episodes" with well-defined standards of practice and higher predictability of resource use	Single, global fee paid to providers to manage all care for given patients over a set period of time • Severity adjusted to account for complexity of medical needs • May include additional Care Management payments to support wellness, prevention and "population health management"	Prepayment for services on a per-member-per-month basis, regardless of service volume or cost • Most commonly used for payment to PCPs • Adjusted for gender and age but does not traditionally take into account health status or clinical acuity

PAYER BURDEN ← → **PROVIDER BURDEN**

Pay For Performance (P4P)	Financial incentives that reward providers for the achievement of a range of payer objectives, including delivery efficiencies, submission of data and measures to payer, and improved quality and patient safety • Can be in the form of a bonus or withhold structure

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A Question of WHEN, Not If . . .

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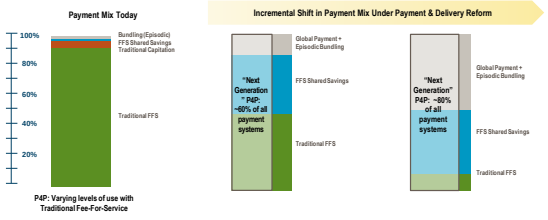

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Payment Reform for Outcomes and Quality

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- **Physician Quality Reporting Initiative**
  Extend payments through fiscal 2014 for the Physician Quality Reporting Initiative, which offers incentives to doctors who report on quality measures to the Medicare Program. It also would expand a feedback program to allow for the development of individual feedback reports for physicians by 2012. Beginning in 2014, if a provider fails to submit quality measures, their Medicare payments would be reduced.
- **Value-based Purchasing Program**
  Establish a hospital value-based purchasing program that pay hospitals based on performance on quality measures. (Effective October 1, 2012) Develop plans to implement programs for skilled nursing, home health agencies and ambulatory surgical centers. (Report to Congress January 1, 2011)
- **Accountable Care Organizations (ACOs)**
  Allow providers organized as ACOs that voluntarily meet quality thresholds to share in the cost savings they achieve for the Medicare program. ACOs must agree to be accountable for the overall care of the Medicare beneficiaries, ensure adequate participation of PCPs, promote evidence-based medicine, report on quality and costs, and coordinate care. (Shared savings program established January 1, 2012)
- **Bundled Payment Pilot**
  Require the HHS Secretary to establish a national pilot program to develop and evaluate paying a bundled payment for acute, inpatient hospital services, physician services, outpatient hospital services and post-acute care services for an episode of care that begins 3 days prior to a hospitalization and spans 30 days following discharge. Establish pilot by Jan. 1, 2013 and expand program by Jan1, 2016, if it is deemed as reducing costs and improving care.

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Accountable Care Organizations

ACO Definition (MedPAC):

"a set of providers [which are held] responsible for the health care of a population of Medicare beneficiaries" and accountable for the overall cost and quality of care for the population"

- **The primary goals of the Medicare Shared Savings Program are to:**
  - Promote provider accountability for a patient population and the coordination of care and services to this population under Medicare parts A and B;
  - Encourage investment in infrastructure and redesigned care processes to drive high quality and efficient service delivery; and
  - Achieve the "Triple Aim" of: (A) better care for individuals; (B) better health for populations; and (C) lower growth in expenditures.
- **Qualifying Medicare ACO requirements:**
  - Willingness to be accountable for quality, cost, and overall care of Medicare fee-for-service beneficiaries for a minimum of three years
  - Have a formal legal structure to receive and distribute shared savings
  - Have at least 5,000 assigned beneficiaries with sufficient number of primary care ACO professionals
  - Report on quality, cost, and care coordination measures and meet patient-centeredness criteria

ACO Core Capabilities

Provider Alignment	Care Delivery	Information Technology	Data Mgmt / Analytics	Payment Setting & Management
• Strengthened Primary Care • PCP / Specialist collaboration • Governance • Organizational Structure • Network Development & Management • Contracting • Financial Strategy & Management • Clinical Program Management • Quality Management	• Episodic Care Management • Population Health Management • Prevention & Wellness • Campaign Management • Consumer Health Tools • Clinical Coaching • Evidenced-Based Protocols • Care Transition Management	• Interoperability • EMR, EHR • Patient Registry • Longitudinal Health Record • CPOE • Clinical Workflow Tools • Decision Support • Provider Portal • HIE • Claims • Billing • Contracting • Benefits • Care Management	• Real-time • Standardized • Actuarial Analytics • Condition Risk Stratification • Patient / Condition Identification • Clinical Outcomes • Quality Reporting • Utilization Reporting • Cost Reporting • Budgeting & Forecasting	• Payment System Strategy • Payment Setting Approach • Severity Adjustment Methodology • Patient Attribution • Payment Transaction Processing • Payment Distribution / Funds Flow

ACO Market Dynamics: Providers and Payers

Providers	▪ ACO development sponsored by hospitals/health systems (but physician led) • Largely private community-based health systems • Focused decision-making structure • Capital capacity to support infrastructure ▪ Used as physician alignment and growth strategy ▪ Building capabilities to manage risk ▪ Becoming insurers (very few)
Payers	▪ Exploring new business models to provide services to ACO's • Claims processing • Case/care management • Analytics (clinical and actuarial) ▪ Enhancing the performance of current products • Improved quality and cost-effectiveness ▪ Development of new ACO insurance products (e.g. co-branded with providers ▪ Developing payer-based delivery systems

Payer-Provider Partnerships

CHALLENGES AND POTENTIAL SOLUTIONS

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Challenges	Potential Solutions

▪ Historically adversarial payer-provider relationships in some markets
▪ Harder to innovate when contract negotiations underway / anticipated
  • Contract negotiations still dominate the payer-provider dialogue
▪ Providers fear greater risk with dominant payer due to greater financial exposure
  • Providers that reduce utilization will see lower revenue from FFS contracts
▪ As physician employment increases, harder to selectively target them as incentivized decision-makers
	▪ Pursue partnerships based on strong payer-provider relationships and/or increased transparency
	▪ Partnership layered upon contract stability
	  • Lower rates offset by subsidy of services / infrastructure
	▪ Models that provide financial alignment
	  • Strongly data driven
	  • Phased downside risk to providers
	  • Preferential physician targeting
	▪ Redefining the relationship and enhancing interdependence
	  • New insurance products
	  • Payers as capital/capital avoidance partners

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Clinical Models are Evolving Too

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- Clinical Integration
- PCMH's
- Initiatives to reduce care variation

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Clinical Integration

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"Clinical Integration is defined as 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."

Advocate Physician Partners

Memorial Hermann

Clarian Health

Henry Ford Health System

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Hallmarks of True Clinical Integration

An analysis of any physician network's clinical integration program is essentially a three-part test which asks:

1. Whether the network's clinical integration program is **"real"** containing authentic initiatives, actually undertaken by the network, which involve all physicians in the network, and apply to the physicians' practice patterns relative to patients who obtain health benefits under fee-for-service health plans;
2. Whether the initiatives of the program are designed to achieve **likely improvements** in health care quality and efficiency; and
3. Whether joint contracting with fee-for-service health plans is **"reasonably necessary"** to achieve the efficiencies of the clinical integration program.

Source: Henry Ford Physician Network

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Henry Ford Physician Network (HFPN) Clinical Integration Core Tenets

The Henry Ford Physician Network is an active and ongoing program developed to evaluate and modify practice patterns of physician participants and create a high degree of interdependence and cooperation among it's physicians to control costs and ensure quality.

Enhanced Accountability
- Quality measures / benchmarking to set performance expectations
- Peer-to-peer, physician-directed counseling
- Remediation activities to ensure accountability

Dissemination of Best Practice
- Provide the forum, continuing medical education, and process support to assure that leading practice is communicated in a timely and efficient manner and consequently adopted into standard practice

Performance Measurement
- Quality measures used across the network
- Benchmarking based on leading practices
- Performance expectations linked to reward structures

Practice Support / Tools
- Access to systems, resources, and services to support practices in program implementation

Improved Care Coordination
- Improved communication and processes among providers of care including primary, specialty, and ancillary care

Patient Engagement Tools
- Health assessments, patient and provider messaging, health information, and health coaching

Source: Henry Ford Physician Network

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Henry Ford Physician Network Physician Performance Measurement

- Each physician has at least 5 meaningful specialty specific metrics to be measured against for performance
- Physicians must comply with the established process for providing clinical data
- Physicians will participate in metric reviews through regional clinical management forums
- Physicians will participate in required training around the quality metric process and performance targets

Measures by Category

		Medical Specialties																					Surgical Specialties										
	TOTAL	FCP	Pediatrics	Allergy/Immunology	Psychiatry/Behavioral Health	Cardiology	Critical Care/Intensivist	Dermatology	Emergency Medicine	Gastroenterology	Geriatrics	Hospitalist	Infectious Disease	Nephrology	Neurology	Oncology	Pain Management	Pulmonology	Endocrinology	Radiology	Rheumatology	Cardiothoracic Surgery	General Surgery	Neurosurgery	OB/GYN	Ophthalmology	Orthopedic Surgery	Otology	Plastic Surgery	Urology	Vascular Surgery
Utilization/Efficiency	7	4	3	1	2	3	0	0	3	2	1	3	1	3	4	2	4	0	3	0	4	0	3	3	4	1	2	3	3	2	2	3
Quality Processes	77	13	11	8	5	7	8	7	8	6	10	10	11	5	8	6	6	2	9	3	7	5	16	11	6	14	6	12	8	6	8	12
Administrative	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
Patient Satisfaction	1	0	0	0	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Clinical Outcomes	16	5	1	1	0	3	2	0	0	3	0	0	0	3	0	0	0	0	1	0	0	0	1	1	2	4	1	2	1	1	1	1
Total	104	25	18	13	10	16	13	10	15	14	14	17	15	14	15	11	13	5	16	6	14	8	23	18	15	22	12	20	15	12	14	19

Source: Henry Ford Physician Network

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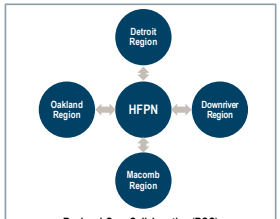
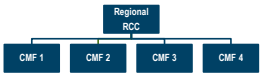
Henry Ford Physician Network Functional Structure



Regional Care Collaborative (RCC)

- Coordinated by a RCC Medical director responsible for implementing HFPN initiatives locally
- Administer / Manage Clinical Management Forums
- Aggregate to impact quality, efficiency, and costs through dialogues with other HFPN physicians in that region
- Collaborate with local leaders on local initiatives
- Peer review and remediation



Clinical Management Forums

- Promote collaboration between HFPN physicians
- Promote and disseminate best practices to HFPN members
- Provide appropriate clinical outlier case review
- Execution forum for utilization management programs

Source: Henry Ford Physician Network

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Henry Ford Physician Network (HFPN) Board of Trustees

	APPOINTED TRUSTEES: (½ Appointed HFMG Trustees, ½ Appointed Non-HFMG Trustees).		EX-OFFICIO TRUSTEES: Serve by virtue of indicated office.
	APPOINTED HFMG TRUSTEES	APPOINTED NON-HFMG TRUSTEES	
2011	5	5	▪ HFHS Chief Financial Officer ▪ HFMG Chief Executive Officer ▪ HFHS Physician Trustee (Private Practice) ▪ HFPN President and CEO (Interim) ▪ HFHS President and CEO Designee
2012	6	6	▪ HFHS Chief Financial Officer ▪ HFMG Chief Executive Officer ▪ HFHS Physician Trustee (Private Practice) ▪ HFPN President and CEO (Interim) ▪ HFHS President and CEO Designee

Source: Henry Ford Physician Network

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Patient-Centered Medical Homes

PCMH is an approach to providing comprehensive primary care that coordinates with sub-specialists when appropriate. It fosters partnerships between individual patients, and their personal providers, and when appropriate, the patient's family

- Each patient has a **personal physician** who provides first contact, continuous and comprehensive care.
- The personal physician leads a **team** of individuals at the practice level for ongoing care and prevention.
- Care is **coordinated** across medical subspecialties, hospitals, home health agencies and nursing homes, and also with the patient's family and public and private community-based services.
- Care is facilitated by **electronic health records and other information technologies**. Analytic tools allow for patient tracking, clinical monitoring, specialist follow-up, population-based decision making, and predictive modeling.
- **Access** is facilitated by open scheduling as well as expanded and after-hours access to personal physician and practice staff by telephone and through secure e-mail.
- **Targeted financial incentives** reward physicians and providers for supporting medical home features, including additional payments for cost savings and measureable and continuous quality improvement.

Source: NCQA

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Approach to Care Variation Management

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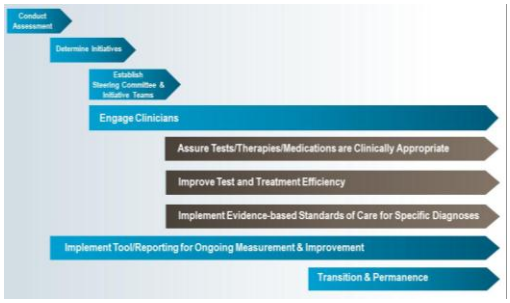
Within targeted opportunity areas, Care Variation Management ensures care is clinically appropriate and delivered efficiently according to evidence-based standards.



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Reducing Variation in Care

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- Improved patient flow
  - Length-of-stay (LOS) reductions
  - Critical and intermediate care reductions
  - Decreased resource consumption
- Improved quality
- Improved patient satisfaction

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Improving Patient Flow and Reducing Variation

PATIENT SATISFACTION SCORES INCREASE

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Examples of patient satisfaction improvement scores from *"Increasing Patient Satisfaction: A Key Benefit of Improving Patient Flow Performance"* white paper

Press Ganey Survey Sample Questions			
	Hospital of the Univ. of Pennsylvania	**The University Hospital, Cincinnati**	**Children's Hospital Colorado**
Likelihood of recommending hospital	N/A	2.4*	3.8*
Nurses kept you informed**	1.8*	2.8*	4.7*
Physician kept you informed	1.5*	0.7	3.0*
Staff included you in decisions regarding treatment**	2.1*	1.4	3.6*
Instructions for home care**	2.3*	0.4	3.9*
Staff worked together to care for you**	1.9*	1.7*	2.7
Felt ready for Discharge**	2.2*	N/A	2.6
Speed of discharge	1.0*	1.0	6.1*
Room Cleanliness**	3.2*	0.8	6.6*

*Denotes a statistically significant increase ($p \leq 0.05$)
**Questions that have a strong correlation with the HCAHPS question, "Would you recommend this hospital to family and friends?"

Intermountain Medical Center saw an improvement in eight targeted patient satisfaction questions related to patient flow:

- Three Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)
- Five "Patient's Perception of Quality" questions
- Four of the eight questions showed statistically significant improvements

Source: "Increasing Patient Satisfaction: A Key Benefit of Improving Patient Flow Performance" Huron Healthcare white paper

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Challenges Facing New ACO's

Moving from FTC-validated Clinical Integration to "True" Clinical Integration

- Expanding the collection of data and dissemination of best practices
- Adherence to evidence-based medicine protocols
- Reducing care variation
- Managing across the continuum of care: PCP's, SNF, LTC, Home Health, Physical Therapy, eHealth, mHealth, etc.
- Executing ACO contracts with payers
- Developing aligned internal funds flow, shared savings and compensation models
- Truly engaging the patient in their ongoing health and wellness

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Managing the Timing of Change

"We are definitely moving toward fixed or bundled payment and away from making margin on volume. The old strategy is quickly becoming the high cost/low margin strategy.

Unfortunately, we get to run these two opposing strategies simultaneously. You can live in two business models for a while, but not forever. How long can we do it?"

Dan Wolterman, President & CEO,
Memorial Hermann Healthcare System, Houston, TX

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What to Do… and When to Do It?

- What makes sense to do now because it's needed now and also works for the future?
- What do you start working on to be ready?
- What to you wait and watch?

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Market Dynamics Favor Integrated Delivery Systems and ACO-like Organizations

- Physician employment and alignment
  - Short term: It's about volume
  - Long term: It's about the IDN
- Narrow networks are here to stay
- Sharing of risk will grow
- Sharing of savings will not!
- Clinical integration… No, real clinical integration!
- Need to "engineer" better care
- Providing lower cost care will require a disciplined focus on operational excellence and utilization
- Transparency
- True patient engagement
- Emerging economy of referral flow
- Local markets will still dominate what happens

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