Accountable Care Collaboratives:

The Drive to High-Value Healthcare

January 2011
**Accountable Care Collaboratives: The Drive to High-Value Healthcare**

Prepared for the 2011 Military Health System Conference, January 24-27, National Harbor, Maryland

*Presented at the 2011 Military Health System Conference, January 24-27, National Harbor, Maryland*
Today’s presentation

- Healthcare reform’s “bending-the-cost-curve” strategy
  - Alignment with DOD’s priority
- Accountable Care Organization: what, when, how?
- Premier’s Accountable Care Collaborative
  - Goals and requirements
  - Component parts
  - Participants
- Regulatory timeline and issues
The hidden agenda

Total Federal Spending for Medicare and Medicaid Under Assumptions About the Health Cost Growth Differential

Percent of GDP

Differential of:
- 2.5 Percentage Points
- 1 Percentage Point
- Zero

Tax rates 2050:
- 10% → 26%
- 25% → 66%
- 35% → 92%
The Overarching Strategic Umbrella of Healthcare Reform

Cuts to Existing FFS System
- Market basket reductions
- DHS cuts
- Nonpayment for anything preventable or unnecessary

Disrupt Existing System
- Bundled Payments
- Innovation Center
- Demonstrations
- ACOs
Changes are upon us now!

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>PAYMENT CUTS &amp; COST SHIFT PROVISIONS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CMS Hospital Behavioral Offset relating to IPPS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Market Basket Reductions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PhRMA Tax (Ranging from $2.5 B to $4.1 B annually)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Productivity Adjustments</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Device Tax (2.9 B annually)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicare DSH Payment Reduction</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Independent Payment Advisory Board (IPPS hospitals exempt until 2020)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicaid DSH Payment Reduction</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>GEOGRAPHIC PAYMENT ADJUSTMENT PROVISIONS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Wage Index</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Geographic Variation Bonus</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>P4P &amp; PENALTIES FOR POOR PERFORMANCE PROVISIONS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RULE MAKING</td>
<td>Hospital Value-Based Purchasing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RULE MAKING</td>
<td>Hospital Readmission Payment Reductions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RULE MAKING</td>
<td>Hospital-Acquired Conditions Penalties</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>TRANSPARENCY PROVISIONS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Waste, Fraud, and Abuse Provisions for Medicare and Medicaid (RACs &amp; MICs)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disclosure of Standard Hospital Charges</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comparative Effectiveness Research</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disclosure of Industry Payments to Physicians and Teaching Hospitals</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| COVERAGE EXPANSION PROVISIONS | | | | | | | | | | |
| Insurance Reforms (Pre-existing conditions for children, no annual or lifetime limits, children on parents insurance until 26) | | | | | | | | | | |
| Medicaid Expansion | | | | | | | | | | |
| Insurance Reforms (Pre-existing conditions for adults, premium limits) | | | | | | | | | | |
| Individual Mandate and Employer “Pay or Play” | | | | | | | | | | |
| State Exchanges | | | | | | | | | | |

| DELIVERY SYSTEM PROVISIONS | | | | | | | | | | |
| RULE MAKING | Accountable Care Organizations | | | | | | | | | |
| Rule Making | Center for Medicare and Medicaid Innovation | | | | | | | | | |
| Rule Making | Bundled Payments Pilot | | | | | | | | | |
## Payment reform across the payment silos

### Payment Models

<table>
<thead>
<tr>
<th>Physician</th>
<th>Outpatient Hospital and ASCs</th>
<th>Inpatient Acute Care</th>
<th>Long Term Acute Care</th>
<th>Inpatient Rehab</th>
<th>Skilled Nursing Facility Care</th>
<th>Home Health Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>RBRVS</td>
<td>APC</td>
<td>MS-DRG</td>
<td>MS-DRG</td>
<td>RICs</td>
<td>RUGs</td>
<td>HHRGs</td>
</tr>
<tr>
<td>VBP modifier plan published by 1/1/2012</td>
<td>VBP implementation plan submitted to Congress by 1/1/2011</td>
<td>VBP commences 10/1/2012</td>
<td>VBP test pilot by 1/1/2016</td>
<td>VBP test pilot by 1/1/2016</td>
<td>VBP implementation plan submitted to Congress by 1/1/2016</td>
<td>VBP implementation plan submitted to Congress by 1/1/2016</td>
</tr>
</tbody>
</table>

### Accountable Care Organizations

- PAC Episode Billing
- Acute Care Episode with PAC Bundling
- Acute Care Bundling
- Medical Home

---

Copyright © 2010 Premier, Inc. All rights reserved.
The DOD & the Nations Ultimate Goal

• **Readiness**
  – Pre- and Post-deployment
  – Family Health
  – Behavioral Health
  – Professional Competency/Currency

• **Population Health**
  – Healthy service members, families, and retirees
  – Quality health care outcomes

• **A Positive Patient Experience**
  – Patient and Family centered Care, Access, Satisfaction

• **Cost**
  – Responsibly Managed
Accountable Care Organizations:
Healthcare reform provision

- Broad range of providers able to initiate ACOs
- Accountability for total cost, quality and care of beneficiaries
- 3-year participation commitment
- Legal structure to receive and distribute savings
- Primary care physicians to cover a minimum of 5,000 Medicare beneficiaries
- Defined processes for evidence-based medicine and patient engagement, quality and cost measures reporting and telehealth, remote patient monitoring, etc.
- Patient-centeredness
- No participation in other government-based shared savings demonstration projects
- Allows CMS to join existing ACOs with payment models beyond fee-for-service
- CMS may give preference to ACOs already contracting with private market
- Saves $4.9 B over 10 years
- Allows pediatric providers to form ACOs through state Medicaid programs (2012)
ACO Shared Savings

Physician Group Practice (PGP) - CMS Demo

- Test bed for demonstrating ACO models
- Creates incentives for physician groups to coordinate the overall care delivered to Medicare beneficiaries
- Shared savings based on improved quality and cost efficiency
- Enables collaboration among providers to benefit Medicare beneficiaries
- Demo goals (5 year demonstration):
  - Coordination of Part A and Part B services
  - Promote cost efficiency and effectiveness through investment in care management programs, process redesign, and tools for physicians and their clinical care teams
  - Reward physicians for improving health outcomes (32 quality measures) by sharing in financial savings
PGP Outcomes… So far (as of 8/2009)

• Three-year average quality-improvement results:
  • 10 percentage points on the diabetes,
  • 11 percentage points on the congestive heart failure measures,
  • 6 percentage points on the coronary artery disease measures,
  • 10 percentage points on the cancer screening measures, and
  • 1 percentage point on the hypertension measures.

• Five participants earned $25.3 million in performance payments for improving quality and achieving savings of $32.3 million:
  1. Dartmouth-Hitchcock Clinic
  2. Geisinger Clinic
  3. Marshfield Clinic
  4. St. John’s Health System, and
  5. The University of Michigan Faculty Group Practice
Journey to high-value healthcare
Definition of Success:
Improving triple aim™ population outcomes

Population Health
Metrics:
- QUEST outcomes
- Select HEDIS metrics
- Health status – SF12
- Mortality rates

Experience of Care
Metrics:
- Patient satisfaction
- PAM Scores (Patient Activation Measures)

Per Capita Costs
Metrics:
- Total medical PMPM
- Total Medical Trend
- Total Rx PMPM
- Admissions/1000
- Readmission rate

The term triple aim is a trademark of the Institute for Healthcare Improvement
Movement Towards ACO Raises Key Questions

- What is the COST impact of delivering accountable care?
- What is the REVENUE impact of delivering accountable care?
- What is the COST impact of building an ACO?
- How do you manage the hospital and physician relationship through transition to an ACO?
- How do you manage two parallel entities through the transition?
- How do you manage the pace of that transition?
ACO model: Six core components

A group of providers willing and capable of accepting accountability for the total cost and quality of care for a defined population.

Core Components

- People Centered
- Health Home
- High-Value Network
- Population Health Data
- ACO Leadership
- Payer Partnerships
Components and Capabilities

**Health Home**
A. Deliver People Centered Primary Care
B. Optimize Chronic, Acute and Preventative Care
C. Manage Population Segments to Optimize Health Status
D. Coordinate Care Across Continuum
E. Health Home Value Care Systems
F. Drive Continuous Improvement in Practice Population Outcomes
G. Develop New Care Models to Improve Specific Clinical Conditions Across the Spectrum of Care

**People Centered Foundation**
A. Involve People in Decisions that Affect their Health Care
B. Provide People with Easy Access to Health Care
C. Activate Individuals to Take Responsibility for their Own Health
D. Regularly Assess and Address Individuals’ and Population’s Needs
E. Measure and Improve the Experience of People within the ACO Population

**High Value Network**
A. Deliver High Value Specialist Care
B. Deliver High Value Outpatient Facility Services
C. Deliver High Value Inpatient Services
D. Deliver High Value Post-Acute Care
E. Integrate and Coordinate Care Across the Spectrum
F. Drive Continuous Improvement in ACO Population Outcomes
G. Develop New Care Models to Improve Specific Clinical Conditions Across the Spectrum of Care

**Payor Partnership**
A. Negotiate and Manage ACO Contract with Payer Partners
B. Design aligning incentive systems for ACO members that may be administered by Payer Partner
C. Collaborate with Payer Partners to Manage Population Experience

**Population Health Data Management**
A. Capture and Analyze Data from Multiple Sources
B. Applications and Systems that Enable Population Health Management
C. Information Exchanges and Communication Pathways for ACO Patients & Participants

**ACO Leadership**
A. Use Reimbursement to Align ACO Participants with ACO Objectives
B. Provide ACO Wide Results Reports to all Participants
C. Communicate Consistently and Routinely to all Participants
D. Provide Strategic Management of ACO Entity
E. Manage ACO as a Combined Physician Hospital Entity
F. Provide Centralized Medical Management Functions
G. Report on and Facilitate Management of Total Medical Cost
H. Manage Intra-ACO Transfer Prices / Costs
I. Manage Financial Performance of ACO
J. Oversee Triple Aim Outcomes for Entire Population
K. Effectively Manage the Operational Transitions Required to Create an ACO
L. Develop an Organizational Culture Consistent with an ACO System
M. Train Physicians and Other Leaders in Leadership Development in Order to Foster Effective Leadership in a New ACO System
N. Enable ACO Contracting
O. Evaluate, Analyze, Establish Appropriate Legal Structure
P. Educate and Appropriately Manage Interactions Across and Between ACO Parties
Q. Impact and Monitor ACO Regulatory and Legislative Environment
Building health home capabilities

**REQUIREMENTS**

- Deliver primary care
- Manage population outcomes
- Optimize chronic disease care
- Coordinate care across the spectrum of care

**COLLABORATIVE DELIVERABLES**

- Physician alignment strategies, including alternative compensation and contracting models.
- Health home models & toolkits
- Health home report set
- Chronic disease care optimization systems
- Predictive modeling tools & techniques
- Case management operations procedures and training program
- Quality improvement common metrics
Building high-value care networks

**REQUIREMENTS**

- Establish high value networks for:
  - Specialists/ancillaries
  - Inpatient care
  - Outpatient facility care
- Drive continuous improvement
- Manage non-par contracts

**COLLABORATIVE DELIVERABLES**

- Physician profiling toolkit
- Inpatient care improvement programs (QUEST)
- Imaging optimization program
- Care models for acute and post acute care
- Episode of care best practice models
- Global payment models
- Transitions of care program
Interested health systems are taking one of two positions

1. We have a business case to rapidly become accountable for the total cost and quality of care for a defined population.

2. We want to explore the implications of “accountability” and begin building some of the capabilities.
Different degrees of commitment for members

ACO Implementation Collaborative

- Ready to begin implementing
- Executive sponsorship & participation
- Payer partner participation
- Physician network & sufficient population base
- Transparency and acceptance of common cost/quality metrics (QUEST)
- Population health data infrastructure
- Participation in work groups and meetings
- ACO contracting vehicle

ACO Readiness Collaborative

- Capabilities assessment to pinpoint focus areas
- Participation in monthly webinars focused on execution strategies (including members of Implementation Collaborative)
- Online portal of ACO content including toolkits, methodologies, and related content
- Preparation to collect population-based measures
- Milestones to keep on track to join the ACO Implementation Collaborative
Inpatient performance improvement a must!

<table>
<thead>
<tr>
<th></th>
<th>Year 1</th>
<th>18 Months</th>
<th>Year 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lives saved</td>
<td>8,043</td>
<td>14,649</td>
<td>22,164</td>
</tr>
<tr>
<td>Dollars saved</td>
<td>$577M</td>
<td>$1.036B</td>
<td>$2.13B</td>
</tr>
<tr>
<td>Patients receiving EBC</td>
<td>24,818</td>
<td>41,130</td>
<td>43,741</td>
</tr>
</tbody>
</table>
## Proposed Phase I measures
Premier ACO Collaborative - Phase 1 measure set

<table>
<thead>
<tr>
<th>AIM</th>
<th>Sub Aim</th>
<th>Final Metric #</th>
<th>Metric Description</th>
<th>Definition Source</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Triple Aim One:</td>
<td>Health of Population</td>
<td></td>
<td>f1</td>
<td>HEDIS: Colorectal Screening, adults 50 - 75</td>
<td>NCQA</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>f2</td>
<td>HEDIS: Breast Cancer Screening, females 40 - 69</td>
<td>NCQA</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>f3</td>
<td>HEDIS: Flu Shot for Older Adults, adults 65+</td>
<td>NCQA</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>f4</td>
<td>HEDIS: Pneumonia Vaccination Status for Older Adults, adults 65+</td>
<td>NCQA</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>f5</td>
<td>HEDIS: Comprehensive Diabetes Care – HbA1c control (&lt;8%), 18-75</td>
<td>NCQA</td>
</tr>
<tr>
<td></td>
<td>Tertiary Prevention - Prevention Related Disease Complications</td>
<td>f6</td>
<td>QUEST: Prevention of Harm (composite)</td>
<td>Premier</td>
<td>Discharge Abstract</td>
</tr>
<tr>
<td></td>
<td></td>
<td>f7</td>
<td>QUEST: Risk Adjusted mortality / 1000</td>
<td>Premier</td>
<td>Discharge Abstract</td>
</tr>
<tr>
<td></td>
<td></td>
<td>f8</td>
<td>QUEST: Composite Score of Evidence Based Care for Hospitalized Cases</td>
<td>Premier</td>
<td>Premier</td>
</tr>
<tr>
<td>Triple Aim Two:</td>
<td>Experience of Care</td>
<td></td>
<td>f9</td>
<td>HEDIS: Global Rating of All Health Care</td>
<td>NCQA</td>
</tr>
<tr>
<td></td>
<td>Satisfaction</td>
<td></td>
<td>f10</td>
<td>HEDIS: Global Rating of Personal Doctor</td>
<td>NCQA</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>f11</td>
<td>HEDIS: Global Rating of Specialist Seen Most Often</td>
<td>NCQA</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>f12</td>
<td>HEDIS: Composites Score of Getting Needed Care</td>
<td>NCQA</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>f13</td>
<td>HEDIS: Composite Score of Shared Decision Making</td>
<td>NCQA</td>
</tr>
<tr>
<td>Triple Aim Three:</td>
<td>Cost per Capita and Services Delivered</td>
<td></td>
<td>f14</td>
<td>Total Cost PMPM (e.g. medical and Rx)</td>
<td>TBD</td>
</tr>
<tr>
<td></td>
<td>Cost PMPM</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Utilization</td>
<td></td>
<td>f15</td>
<td>Total Cost PMPM Trend</td>
<td>TBD</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>f16</td>
<td>Admits per 1000 members / year (possibly w/case-mix)</td>
<td>TBD</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>f17</td>
<td>30 day readmit (all cause) rate</td>
<td>TBD</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>f18</td>
<td>ED Visits/1000</td>
<td>TBD</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>f19</td>
<td>Hospital Admissions for Ambulatory Sensitive Conditions (likely w/ case-mix)</td>
<td>AHRQ</td>
</tr>
</tbody>
</table>
Capabilities Assessment

Assessment of each ACO Component:
Per Capability
Per Operating Activity

Outline of “Needs” per each ACO Component:
Which prioritized Capabilities and Operating Activities require the most focus for your organization?

Overall ACO Implementation Status

Value Driven Health Home

A. Deliver People Centered Primary Care
B. Optimize Chronic, Acute and Preventative Care
C. Manage Population Segments to Optimize Health Status
D. Coordinate Care Across Continuum
E. Health Home Value Care Systems
F. Drive Continuous Improvement in Practice Population Outcomes

Assessment of Overall ACO Status:
Per Each Component
Consideration of Market Forces Alignment to Strategy
Action is Necessary to Meet Possible CMS Timetable

**June – July 2010**
- Work Group Survey, Planning
- WG Kick-offs

**Aug – Sept 2010**
- Baseline Data Collection & Analysis
- ACO Entity
- Care Model Development

**Oct 2010 – Mar 2011**
- Physician Profiling & Selection
- Incentive Payment System

**Apr – Sept 2011**
- Final CMS Regulations
- Prep for CMS Launch

**Oct 2011 – Jan 2012**
- CMS Application Due
- 1/1/2012 CMS ACO Launch

**June – July 2010**
- HH Pilots
- Case Management System
- Cost and Quality Data Systems

**Aug – Sept 2010**
- Patient Centered & Engagement Program

**Oct 2010 – Mar 2011**
- HH Expansion
- Remote Monitoring System

**Apr – Sept 2011**
- Proposed CMS Regulations
- CMS Application Prep
Key design issues

• Beneficiary opt-out, transparency and inducements
• Timely access to A, B & D claims data and beneficiary list
• Encourage other payers (Medicaid, private)
• Legal (anti-trust, anti-kickback…) “safe harbors”
• Hospitals can organize
• Permit partial or full capitation