WHY CLINICAL INTEGRATION? WHY ACO?

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COOPERATIVE OF
AMERICAN PHYSICIANS

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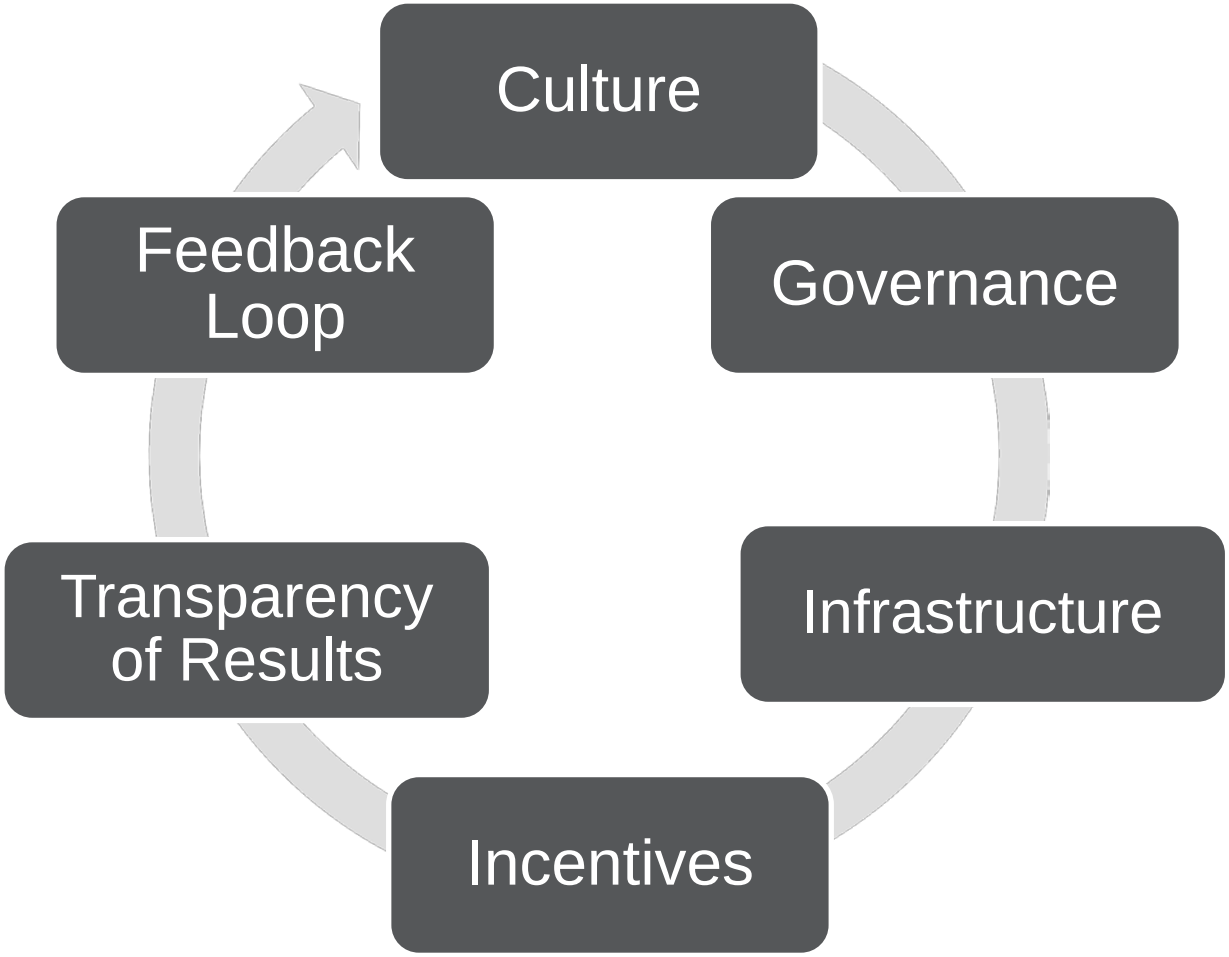
Nothing in today's presentation should be construed as advising or encouraging any person to deal, refuse to deal, or threaten to refuse to deal with any payer, or otherwise interfere with commerce.

LEARNING OBJECTIVES

Participants will be able to:

- Give three benefits of clinical integration for the marketplace, physicians, and hospitals
- Understand the key drivers of clinical integration
- Describe three key aspects of an ACO contract
- Describe approaches to accelerate clinical integration and contracting

KEY DRIVERS



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CLINICAL INTEGRATION: DEFINITION

A structured collaboration among physicians and hospitals on an active and ongoing program designed to improve the quality and efficiency of healthcare.

Joint contracting for fee-for-service managed care arrangements and/or other contract types is a necessary component of this program in order to accelerate these improvements in healthcare delivery.

ACCOUNTABLE CARE ORGANIZATION: DEFINITION

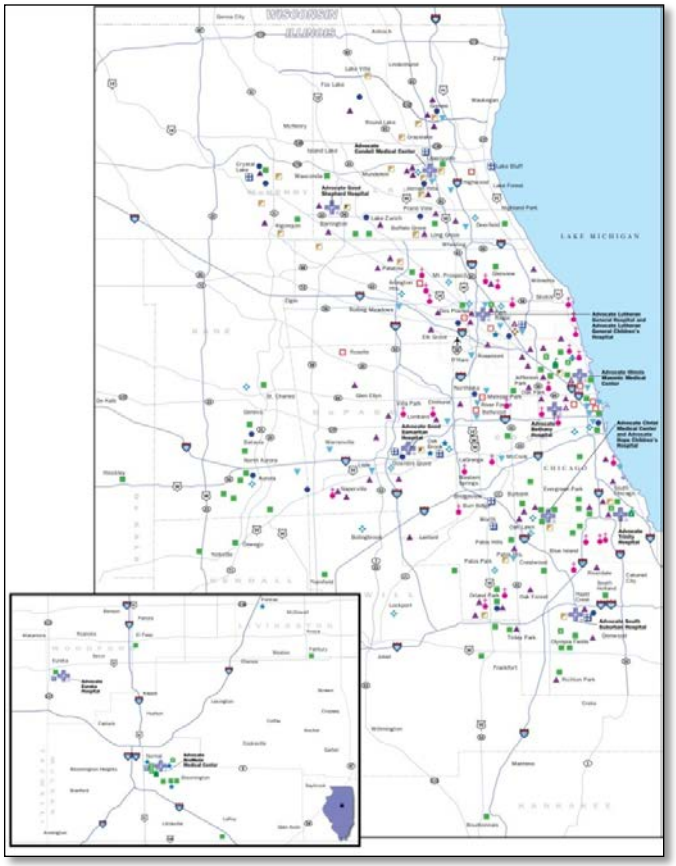
An ACO is an organization that is responsible for both the clinical outcomes and total cost of care for a defined population. Providers are paid primarily on a FFS basis and patients are “attributed” to the ACO based on their choice of providers.

Typically, ACO governance includes physician providers and hospitals or health systems and may include other providers and consumers. The ACO is rewarded for improved clinical outcomes and control of the total cost of care. Typically, the ACO “shares savings” with a payer if quality metrics are met. There may be “downside risk” for providers.

CIN IS THE CHASSIS
AN ACO CONTRACT IS ONE DESTINATION

- A CIN may have multiple types of contracts:
  - Fee-for-Service with Infrastructure Payments (Medical Home, IT, etc.)
  - Fee-for-Service with P4P
  - ACO (Shared Savings) Contracts
  - Limited Risk Contracts
  - Bundled Payments
  - Full-Risk Contracts

ADVOCATE PHYSICIAN PARTNERS



Advocate Physician Partners delivers services throughout Chicagoland and Downstate Illinois.

- Physician membership
  - 1,138 primary care physicians
  - 2,984 specialist physicians
    - Total membership includes 1,300 Advocate-employed physicians
- 10 acute care hospitals and a children's hospital
- Central Verification Office certified by NCQA
- 250,000 Capitated Lives/ 700,000 PPO Lives/ 100,000 MSSP Lives
- 320,000 "Attributable" Lives

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SOME ADVOCATE PERFORMANCE DATA

- Top Quintile of Large Health Systems*
- 5 of Top 100 Hospitals from Advocate*
- Advocate Physician Partners**
  - 175 metrics for 1.4 million patients in registry
  - Top 10-25th percentile performance for all measures with national comparisons
  - 800,000 Patients in Risk or Shared Savings Programs

*Truven Analytics, Modern Healthcare, June 15, 2015

**Pankaj Patel, MD, Senior Medical Director, APP, June, 2015

NAVIGANT HEALTHCARE IS AT THE FOREFRONT OF ADVISING ORGANIZATIONS TOWARD SUCCESS IN THE VALUE PARADIGM

- 24+ Clinically Integrated Network / Commercial ACO projects
- Advisory experience at 6 of the 32 Pioneer ACOs
- Contracted technical advisor to federally funded Exchange Co-Ops
- Authored the industry's best-selling book on ACOs
- Advised on >20 CMS Shared Savings applications
- Consulting to >150 hospitals with CMS bundling analytics and application development
- Consulting to 8 state Medicaid agencies with payment models and Health Benefit Exchange planning
- Multidisciplinary team of strategy, operations, IT, analytical, physician, health plan, and financial experts

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U.S. PER CAPITA GROWTH IN HEALTHCARE SPENDING (PARTICULARLY HOSPITALS) HAS GROWN UNSUSTAINABLE, PARTICULARLY GIVEN OUR OVERALL HEALTH OUTCOMES

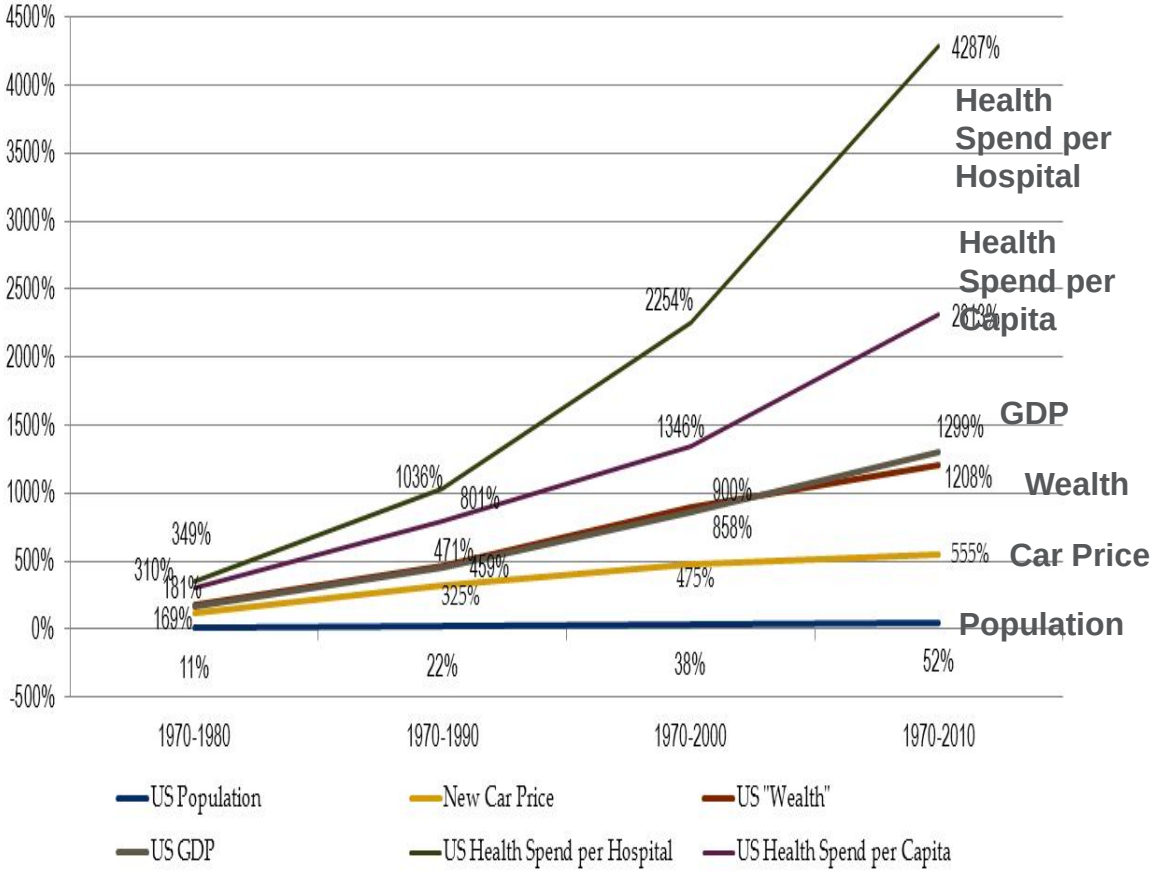
Commonwealth Fund Health Rankings

11 Developed Countries

Category	US Rank
Quality	5
Effective Care	3
Safe Care	7
Coordinate Care	6
Patient-Centered Care	4
Access	9
Cost-Related	11
Timeliness	5

U.S. Health Spend Inflation vs. Other Indicators

1970- 2010



Note: "Wealth" = average household income * total households.

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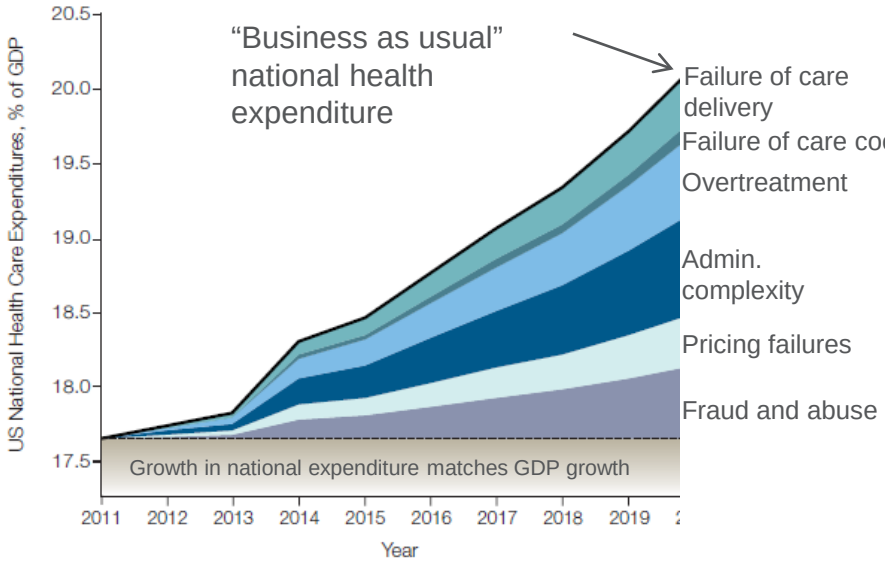
CMS FOCUS ON 'EXCESS COSTS' UNDERLYING ROLL OUT OF PROGRAMS

Drivers of Cost Savings



Estimates of Annual U.S. Healthcare Waste *(in billions)*

	Annual Cost to US Health Care System in 2011		
	Low	Midpoint	High
Failures of care delivery	102	128	154
Failures of care coordination	25	35	45
Overtreatment	158	192	226
Administrative complexity	107	248	389
Pricing failures	84	131	178
Fraud and abuse	82	177	272
Total	**558**	**911**	**1264**
% of Total Spending	**21%**	**34%**	**47%**

- Savings estimates across the system **range from 21-47%**
- Largely driven by lack of **care coordination/failure in care delivery, overtreatment, and administrative complexity**
- How are policy experts and payers designing programs to drive out such costs? What is the impact to providers?

Source: JAMA. 2012;307(14):1513-1516; Berwick, MK; "Eliminating Waste in US Health Care"

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MARKET DYNAMICS ARE DISRUPTING THE OPERATING MODELS OF INDEPENDENT COMMUNITY-BASED HEALTH SYSTEMS AND PHYSICIANS

1 Cost Increases for Government, Payors and Employers

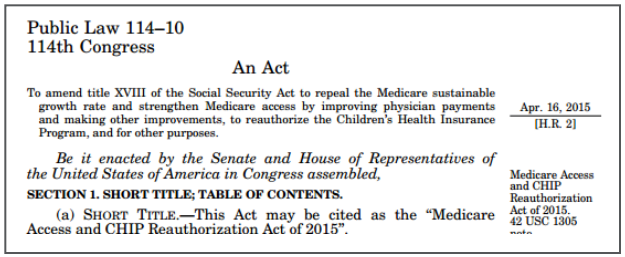
70% Increase in Employer Premiums[1] (2002-2013)

6.5% Increase in Exchange Premiums[2] (2015-2016)

2 The Medicaid Expansion & Emergence of Health Insurance Exchanges

3 Cost shifting from government, employers & health plans to providers, with a focus on total cost of care and risk-sharing

4 MACRA places greater reporting and performance burdens on physicians



Public Law 114–10
114th Congress

An Act

To amend title XVIII of the Social Security Act to repeal the Medicare sustainable growth rate and strengthen Medicare access by improving physician payments and making other improvements, to reauthorize the Children's Health Insurance Program, and for other purposes.

Apr. 16, 2015
[H.R. 2]

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

Medicare Access and CHIP Reauthorization Act of 2015.
42 USC 1305

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Medicare Access and CHIP Reauthorization Act of 2015".

5 Provider Consolidation & Collaboration

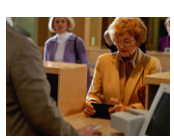
Ascension Health, CHE Trinity Health Form Clinically Integrated Network

Written by Helen Adamopoulos (Twitter | Google+) | May 07, 2014

CHE Trinity Health, based in Livonia, Mich., and St. Louis-based Ascension Health have collaborated with physician leaders in Michigan to create a statewide clinically integrated network of healthcare providers.

Note 1: Center for Healthcare Research and Transformation, 9/2015

OTHER SERVICE INDUSTRY TRANSFORMATIONS…

Industry	Then (1980)	Today
Banking	 	 
Airline Tickets		 
Telecom		
Consumer Electronics		 
Music		 

…FOCUSED ON THE NEEDS OF THE CUSTOMER

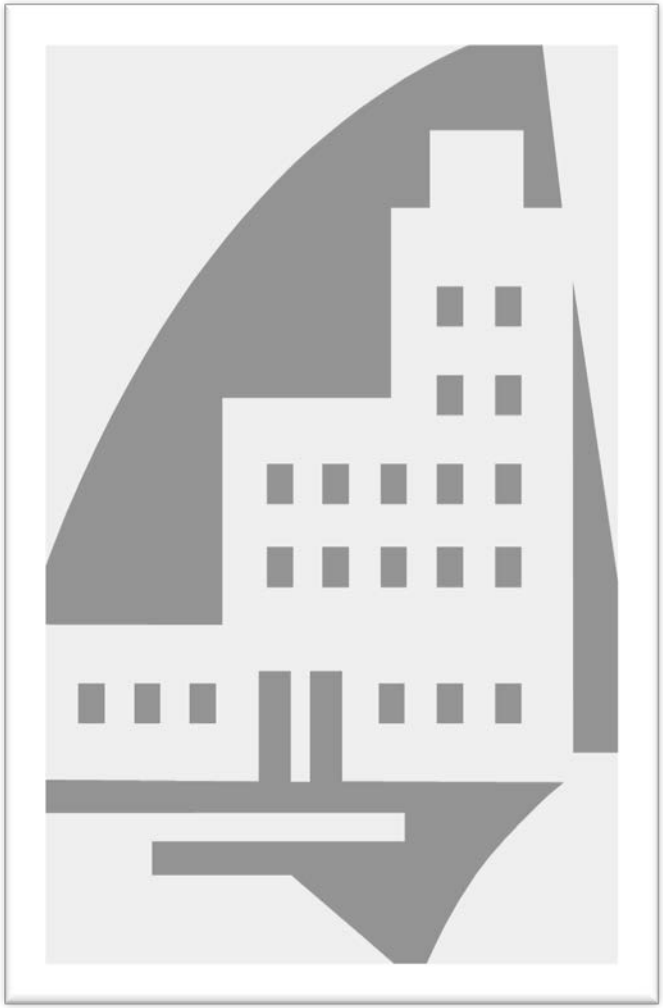
Industry	Then (1980)	Today
Television		
Mail		
Information		
Books		
News	 	 

VALUE FOR PHYSICIANS: **BETTER CARE, MORE PATIENTS, BETTER PAY**

Bill Mayer

- Enhanced marketplace visibility
- Access to patients through contracts
- Focus on outcomes; pride in collective accomplishments
- Additional work compensated through incentives
  - Improved potential for success in Value Based Contracts
- Practice infrastructure support
- Interface with multiple insurers
- Improved physician-hospital alignment
- Coordination of in-network care with specialists

VALUE FOR HOSPITALS



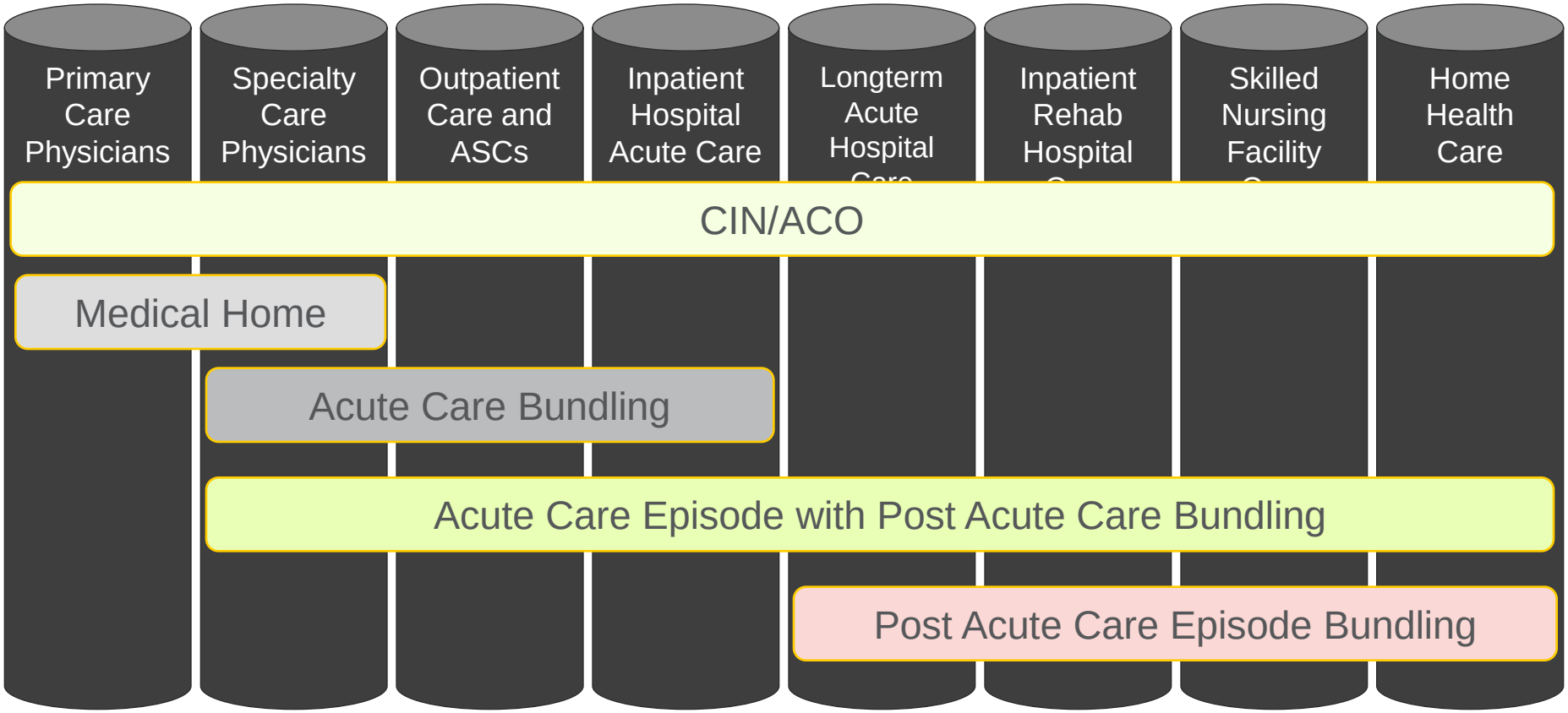
- Creates business partnership with key physicians
- Strengthens in-network care coordination
- Focuses physicians on hospital goals
  - Patient safety
  - Costs
- Positions for Value-Based Payments
  - Readmission avoidance
  - Bundled Payments
  - Quality/Safety Bundles
  - ACOs

VALUE FOR THE MARKETPLACE

- Focus on clinical outcomes
- Demonstration of efficiencies
- Commitment to ongoing improvement
- Stable/cohesive network
- Transparency of results
- Physician-led organization

REDEFINE YOUR CORE BUSINESS
…TO BEING IN THE CARE COORDINATION BUSINESS

Transforming Fragmented Silos Into Coordinated Care



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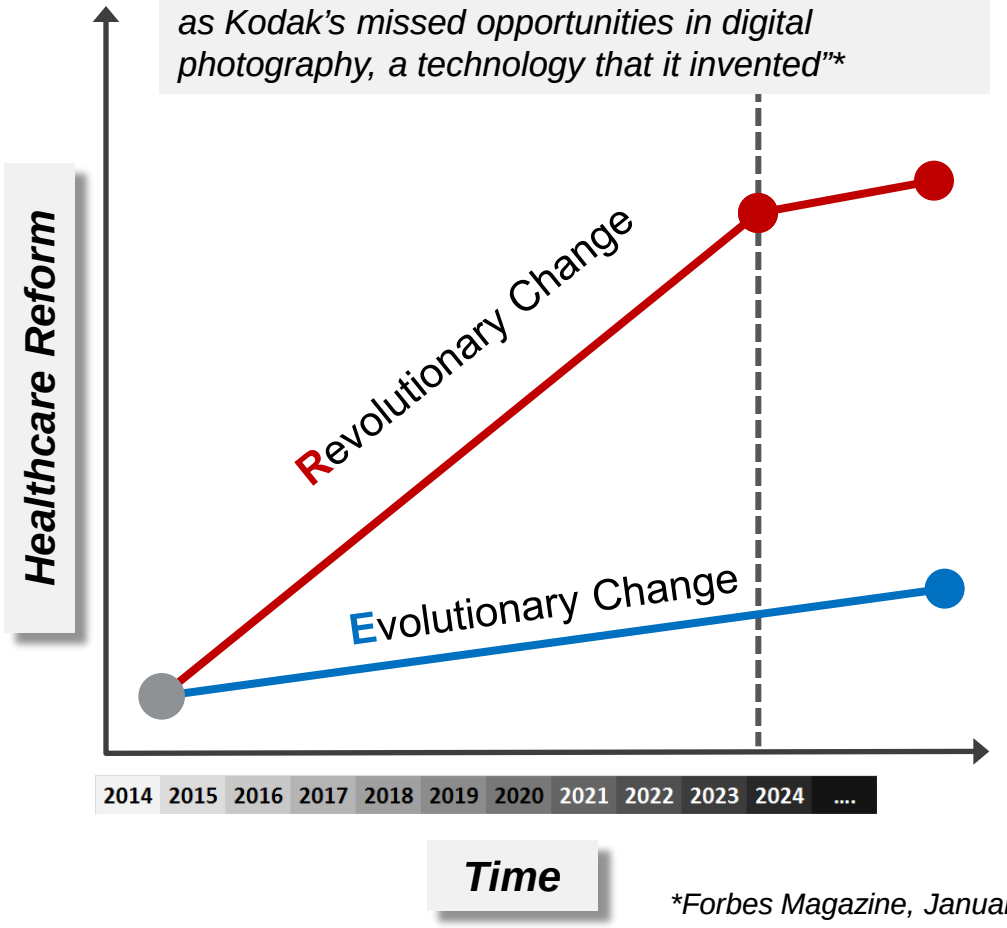
REDEFINE YOUR CORE BUSINESS
DON'T FALL VICTIM TO THE 'KODAK SYNDROME'

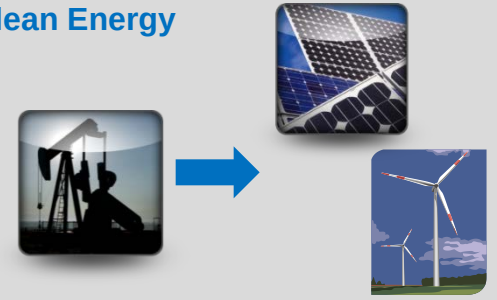
*"There are few corporate blunders as staggering as Kodak's missed opportunities in digital photography, a technology that it invented"**



….for example:

Digital Photography

Clean Energy



**Forbes Magazine, January 2012*

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VALUE-BASED CONTRACTS

(QUALITY + SERVICE) / COST = VALUE

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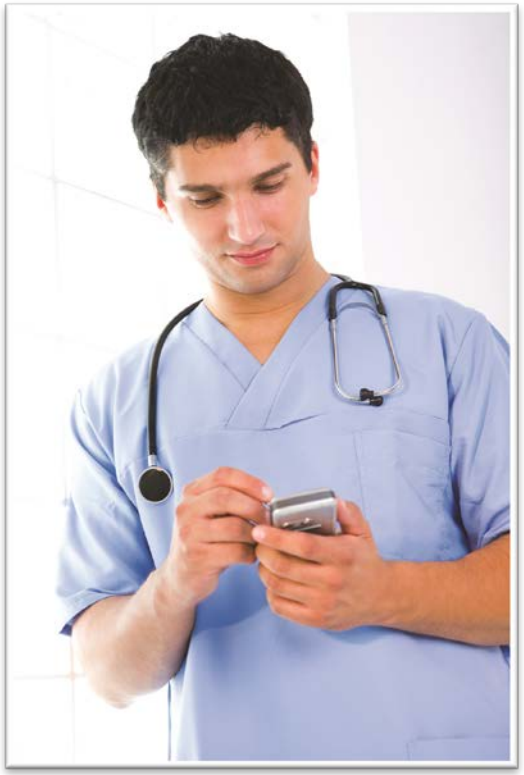
VALUE-BASED PURCHASING REQUIRES INTEGRATION

- Bundled Payments
- Payment Denials
- Medicare Value-Based Purchasing
  - Hospitals and Doctors (SGR Elimination)
- Accountable Care Organizations
- Cost Pressures

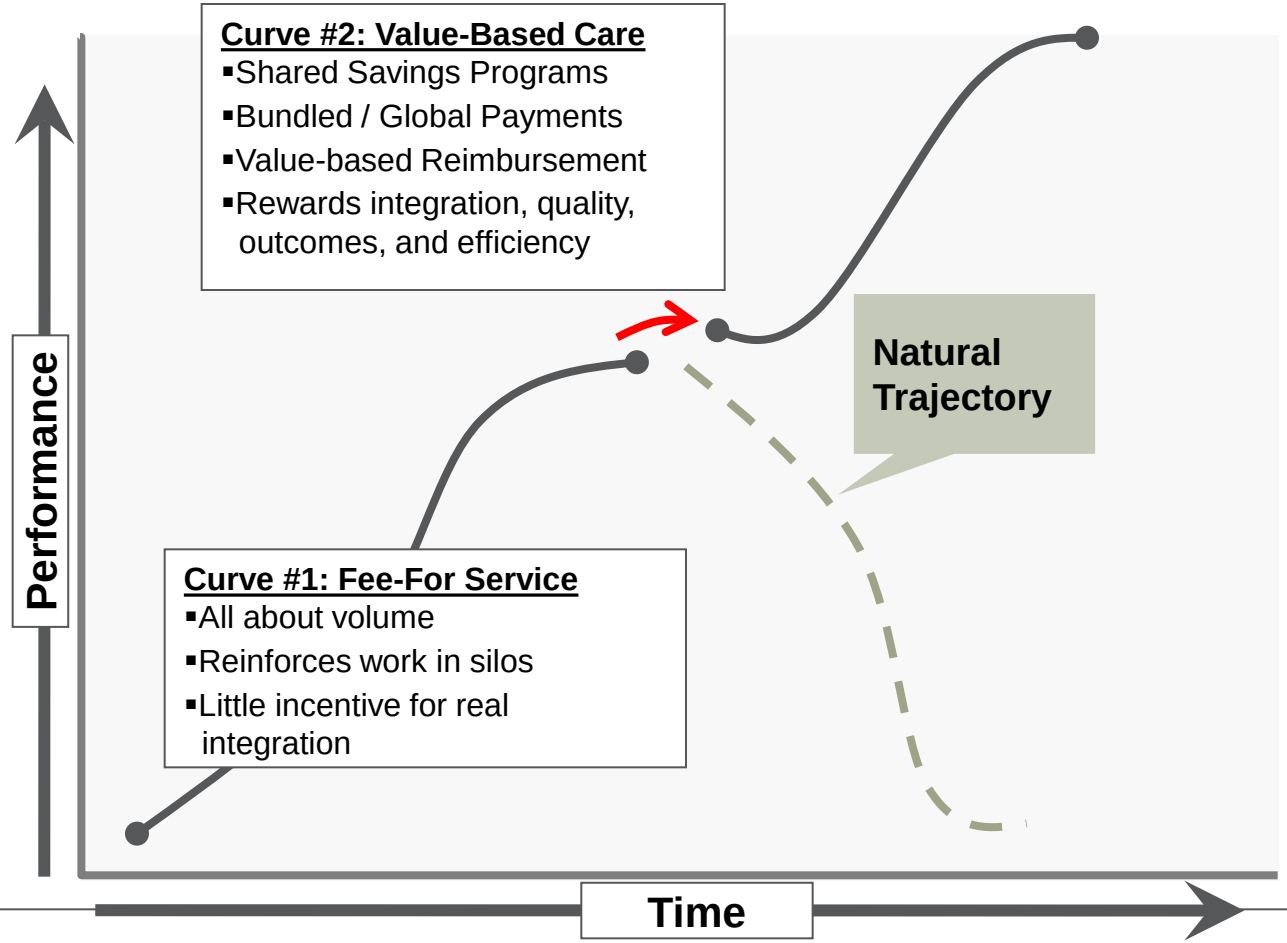


“SKATE WHERE THE PUCK IS GOING, NOT WHERE IT’S BEEN”

From:MacGregor, Roy (1999). "Fortune Smiled Upon Us". In Dryden, Steve. *Total Gretzky: The Magic, The Legend, The Numbers*. Toronto, Ontario: McClelland & Stewart Inc. pp. 14–36. ISBN 0-7710-4177-2.

THE TWO-CURVE DILEMMA HAS LED TO ROBUST GROWTH IN CLINICAL INTEGRATION NETWORKS

The pace of change varies by market but the shift from Curve 1 to Curve 2 will happen regardless of an organization's readiness to make the transition.



	# ACOs
Q2 2011	81
Q4 2011	138
Q2 2012	208
Q4 2012	356
Q2 2013	480
Q4 2013	606
Q2 2014	626
Q1 2015	715

2014 MSSP ACOs Receiving Shared Savings: **26%**

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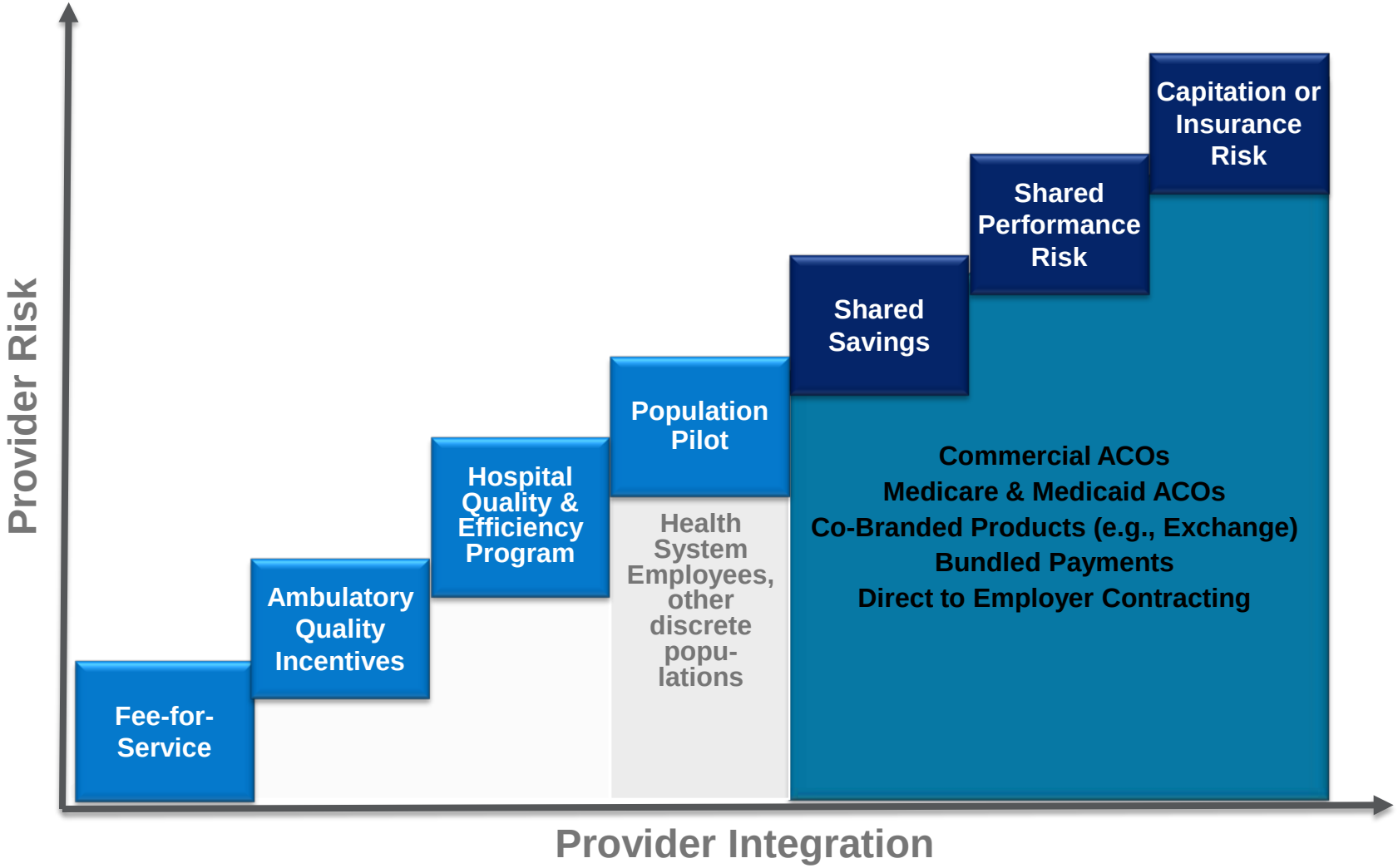
CINS OFTEN PURSUE A PHASED APPROACH IN TERMS OF PROVIDER INTEGRATION & PROVIDER RISK, WHICH ALLOWS THEM TO BUILD THEIR POPULATION HEALTH CAPABILITIES



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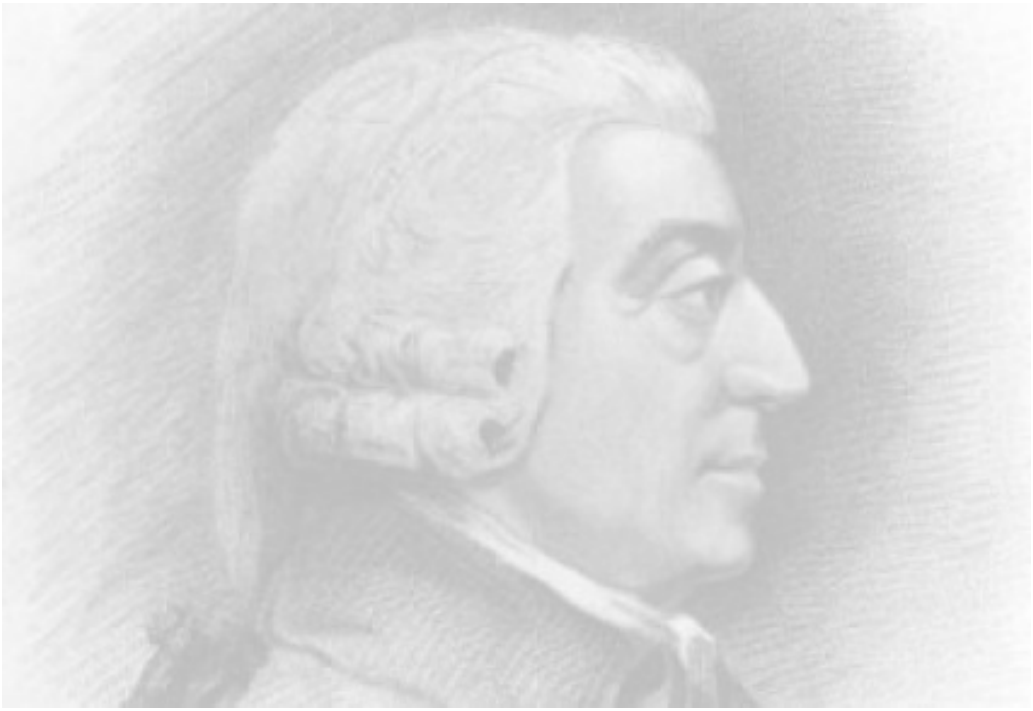
“ONE FOOT ON THE DOCK, ONE IN THE BOAT”

THEIR REWARD MUST BE SUCH

"We trust our health to the physician. Their reward must be such, therefore, as may give them that rank in the society which so important a trust requires. The long time and the great expense which must be laid out in their education, when combined with this circumstance, necessarily enhance still further the price of their labour."



Adam Smith, 1776 • "The Wealth of Nations"
Book 1 • Chapter X

MISCONCEPTIONS ABOUT CLINICALLY INTEGRATED NETWORKS

	Clinical Integration is:
✔	A ***physician-led*** organization
✔	Inclusive of employed & independent physicians
✔	A forum for increased coordination
✔	A vehicle for collective negotiations
✔	An opportunity to be rewarded for value
✔	A seat at the table to lead change

	Clinical Integration is NOT
✘	Physician employment
✘	A hospital-led initiative
✘	A reduction in choice
✘	A limitation in service
✘	Leverage overpayors
✘	Capitation or financial risk

DEVELOPING A SUCCESSFUL CIN CULTURE

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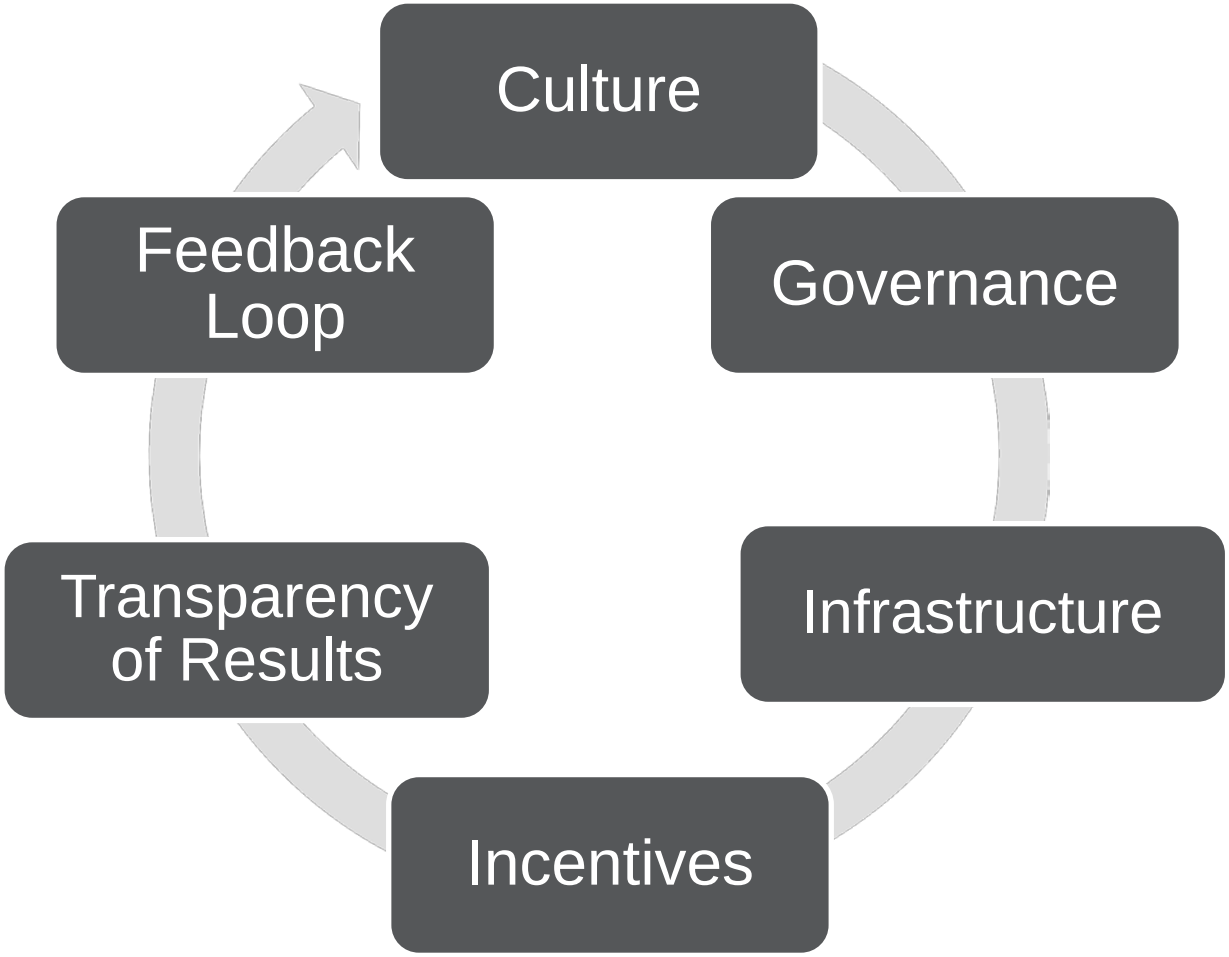
KEY DRIVERS



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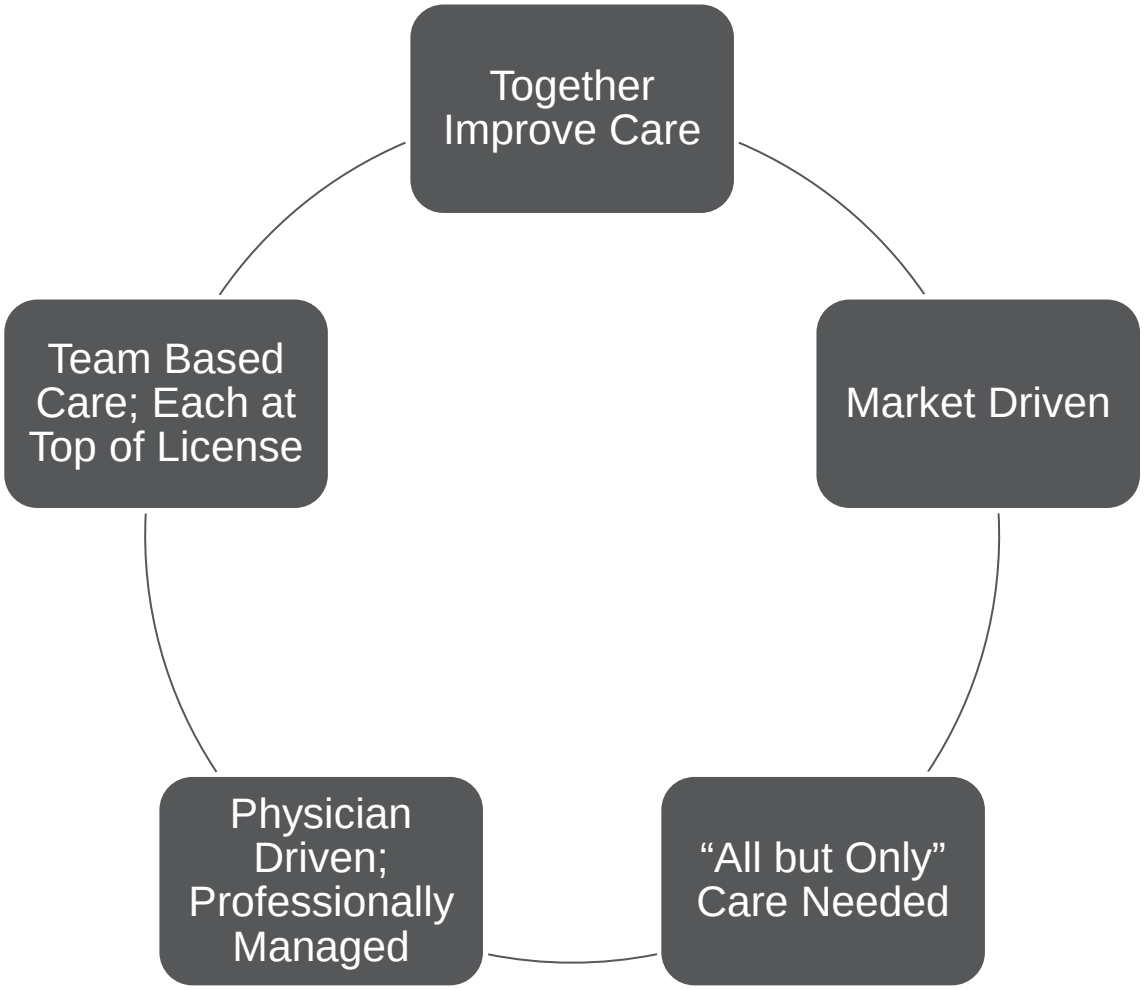
CULTURE

- “How things are done around here”

- “What people do when no one is looking”

FIVE ASPECTS OF CIN CULTURE



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CLINICAL INTEGRATION CULTURE

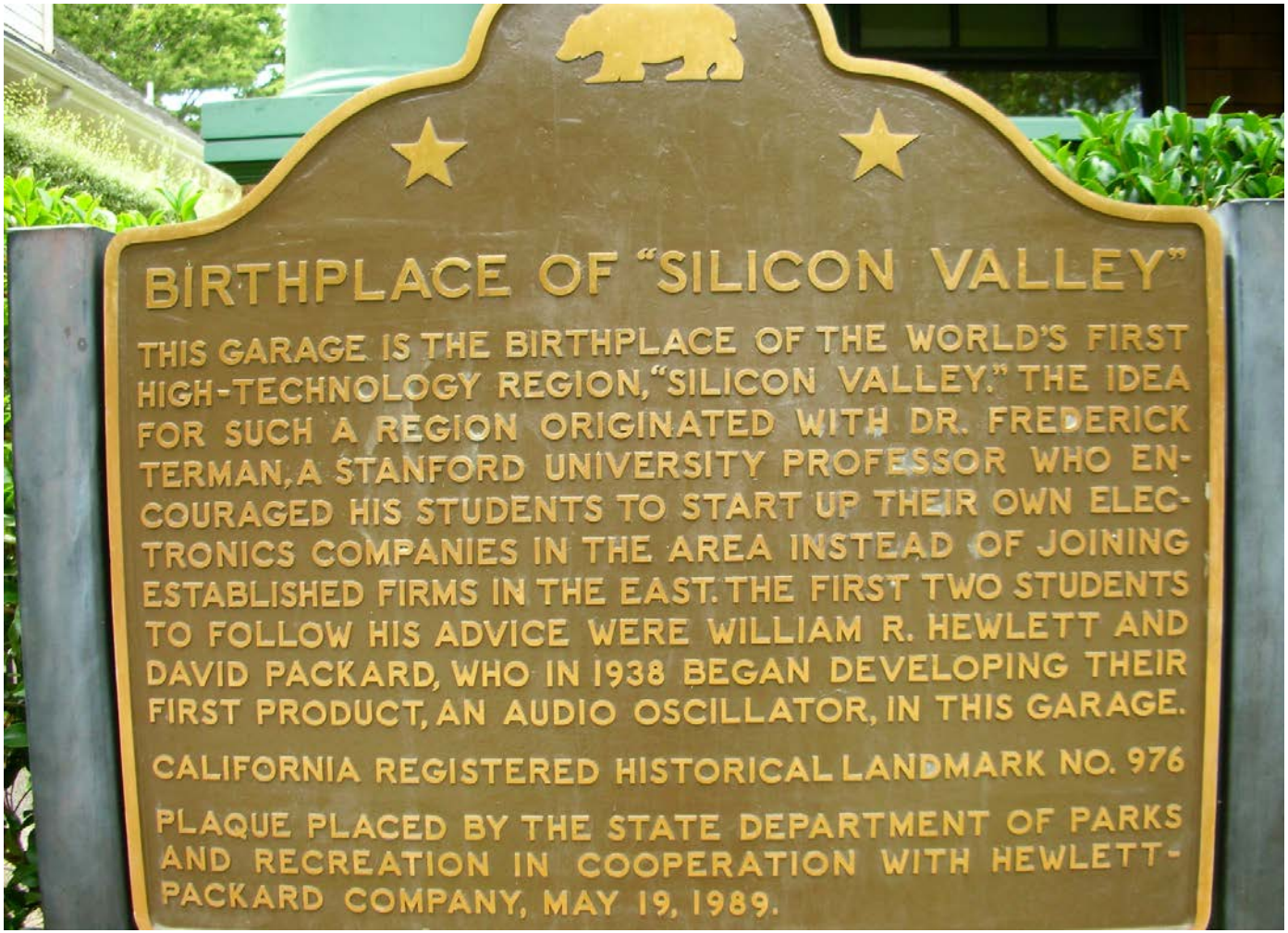
FROM...	TO...
Runs own practice	Accepts decisions by leadership selected by peers
Physician determines “best practices”	Peer physicians, with literature, determine “best practices”
Traditional practice structure, functions, and staffing	Innovation in practice design, team, services
Practice designed around physician needs	Organization strives to serve patients and other market needs

EMPLOYMENT VS. ALIGNMENT

"Putting a tiger on a chain does not make it a pet."

Shawn Griffin, MD
Memorial Hermann Physician Network

‘RIGHT PEOPLE ON THE BUS’
HEWLETT PACKARD



A CULTURE OF ENGAGED PHYSICIANS

- “Right People on the Bus”
- Physician engagement in governance
- Physician leadership development
- Shared identity/values → “membership”
- Appeal to pride and sense of excellence
  - Recognition for quality and efficiency
  - Consistent use of evidence-based medicine
  - Power of the outcomes of the group

CLINICAL INTEGRATION PRIMER & BEST PRACTICES

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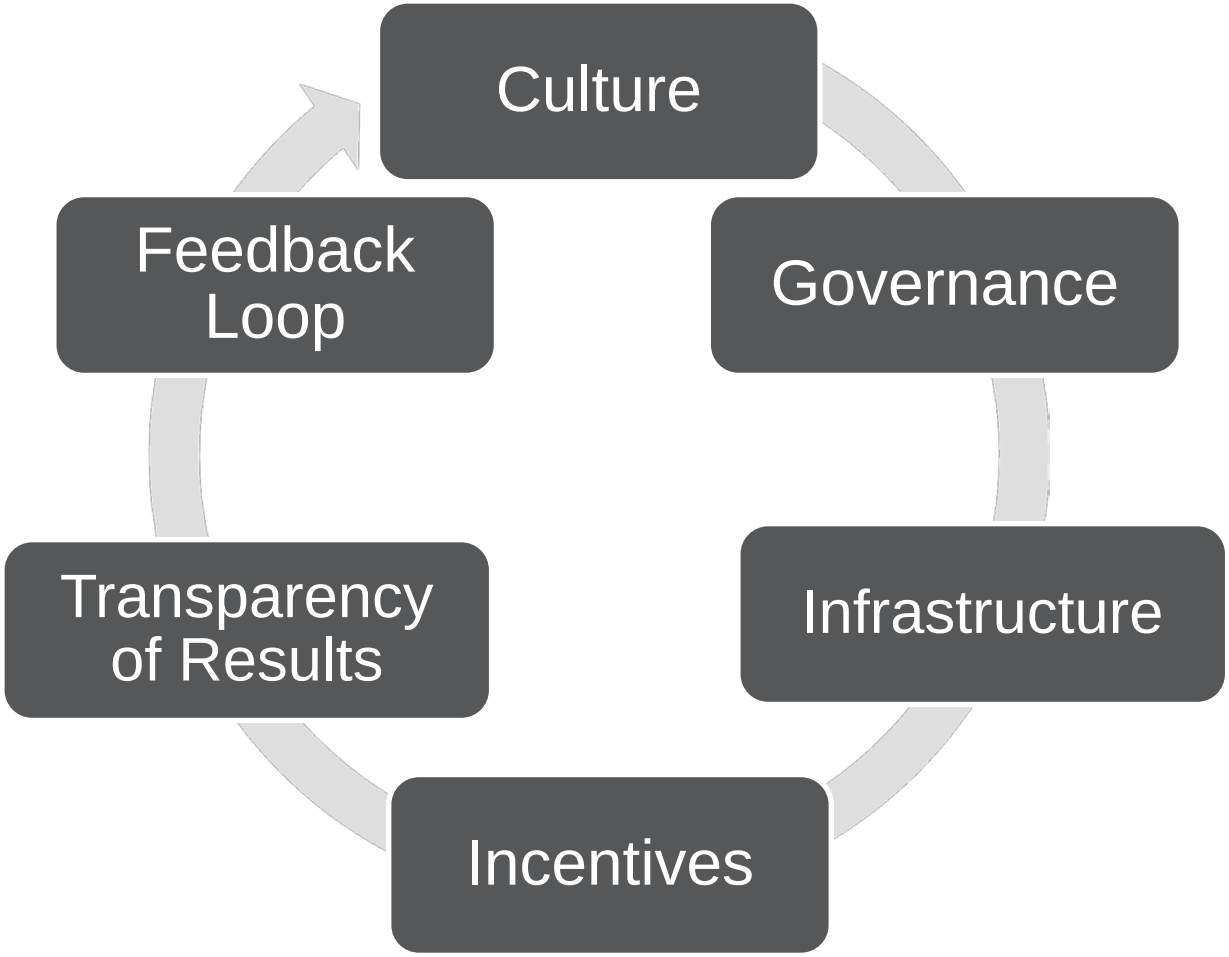
KEY DRIVERS



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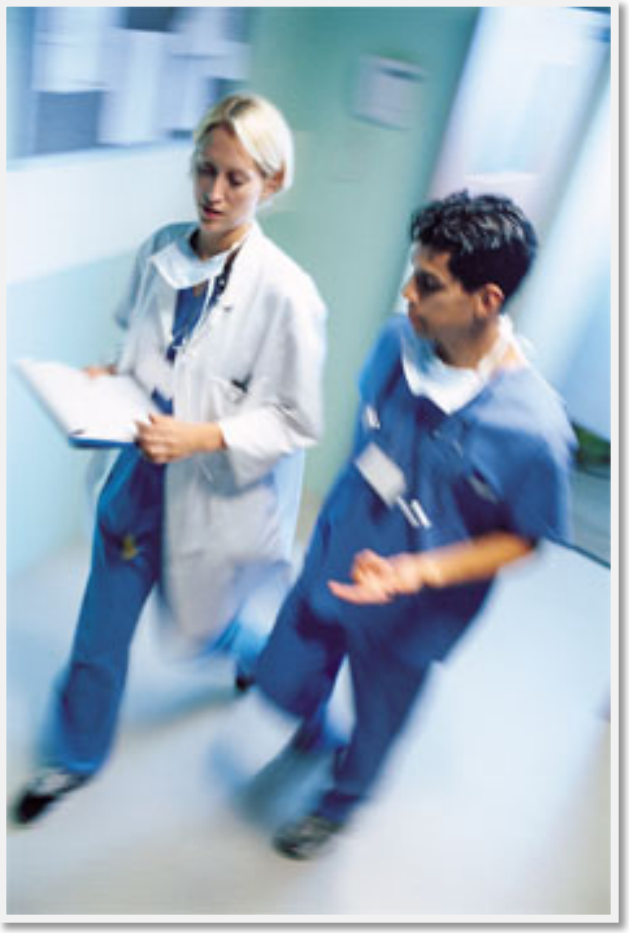
CINS MUST CREATE A COHESIVE NETWORK WITH A ROBUST INFRASTRUCTURE CAPABLE OF DELIVERING VALUE TO THE COMMUNITY

Building Blocks	Goal
1. Physician Leadership & Alignment	Develop a physician-led, professionally managed culture inclusive of a wide range of medical specialties fully engaged in clinical transformation efforts
2. IT Systems & Analytics	Enable clinical integration and population health through world class IT connectivity, data analytics, and reporting
3. Care Coordination & Management	Coordinate care across the continuum to deliver an efficient and cost effective delivery model
4. Clinical Effectiveness	Create a robust clinical effectiveness infrastructure using sophisticated data analytics and an engaged physician base to achieve triple aim goals
5. Contracting & Finance	Pursue a contracting strategy based on performance risk; incentivize both primary care and specialist providers using an internal distribution model
6. Network Development	Retains a provider network with the right size, composition, geography, and performance to achieve success
7. Patient Engagement	Engage patients in care decisions to maintain healthy populations and improve health of sick patients

CRITICAL SUCCESS FACTORS



- Physician driven; professionally managed
- Same metrics across all payers
- Minimize Additional Administrative Costs
- Additional funds recognize extra work by physicians and staff
- Infrastructure necessary to support improvement
- Physician/hospital alignment

VALUE FOR PHYSICIANS: **BETTER CARE, MORE PATIENTS, BETTER PAY**

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- Practice infrastructure support
- Interface with multiple insurers
- Improved physician-hospital alignment
- Coordination of in-network care with specialists

HEALTH AFFAIRS ARTICLE

WEB FIRST

By Mark C. Shields, Pankaj H. Patel, Martin Manning, and Lee Sacks

A Model For Integrating Independent Physicians Into Accountable Care Organizations

DOI: 10.1377/hlthaff.2010.0824
HEALTH AFFAIRS 30,
NO. 1 (2011): –

ABSTRACT The Affordable Care Act encourages the formation of accountable care organizations as a new part of Medicare. Pending forthcoming federal regulations, though, it is unclear precisely how these ACOs will be structured. Although large integrated care systems that directly employ physicians may be most likely to evolve into ACOs, few such integrated systems exist in the United States. This paper demonstrates how Advocate Physician Partners in Illinois could serve as a model for a new kind of accountable care organization, by demonstrating how to organize physicians into partnerships with hospitals to improve care, cut costs, and be held accountable for the results. The partnership has signed its first commercial ACO contract effective January 1, 2011, with the largest insurer in Illinois, Blue Cross Blue Shield. Other commercial contracts are expected to follow. In a health care system still dominated by small, independent physician practices, this may constitute a more viable way to push the broader health care system toward accountable care.

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Pankaj H. Patel is medical director of quality improvement and chair of the QI and Credentialing Committee for Advocate Physician Partners, in Mt. Prospect.

Martin Manning is president of Advocate Physician Partners, in Oak Brook, Illinois.

Lee Sacks is executive vice president and chief medical officer of Advocate Health Care and chief executive officer of Advocate Physician Partners, in Oak Brook.

The Affordable Care Act of 2010 included several delivery system reforms intended to address deficiencies in the way health care is

accountable care organizations across the United States. First is the dominance of solo and small-group independent physician practices that provide care to the majority of the US

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