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Providing Accountable Care: Strategy & Structure Webcast Series

Accountable Care Organizations: Payor-ACO Payment Issues

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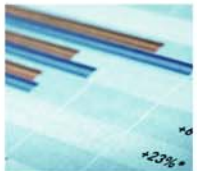
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Overview of Medicare Fee-for-Service (“FFS”) Accountable Care Organization (“ACO”)

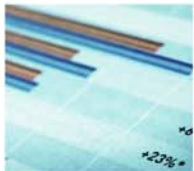
- Medicare fee-for-service (“FFS”) ACO is an organization of physicians and other health care providers accountable for the overall care of at least 5,000 Medicare beneficiaries who are assigned by CMS to that ACO (§ 3022 of the PPACA)
- Medicare FFS ACOs that meet minimum quality standards are to be financially incentivized by CMS to provide higher quality care and overall cost savings (“Shared Savings”)
- Effective January 1, 2012: Three-year agreement with HHS



Recent CMS Announcements

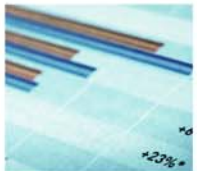
December 3, 2010 – CMS Head Donald Berwick stated:

- CMS will inform Medicare beneficiaries when they are assigned to an ACO
- Draft ACO regulations, originally to be released in Fall 2010, expected to be issued “mid-January 2011”; then “Mid-March”; then “end of March”
- Will January 1, 2012 ACO effective date slip in similar fashion?



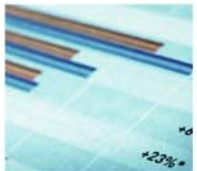
Requirements for Medicare FFS ACOs (cont'd)

- ACO must have formal legal structure permitting receipt and distribution of any shared savings and quality bonuses to participating providers (e.g., physician group practice or network, physician-hospital joint venture, medical foundation, hospital-employed physicians, or any other form app'd by Sec'ty of HHS.)
- Primary Care Physician (PCP)-driven; ACO must have sufficient number of PCPs for assigned panel patients (to be determined by CMS)
- As a practical matter, each PCP should have a participating provider contract with only one ACO (as with earlier Medicare Demonstration Projects and Dartmouth/Brookings Model)



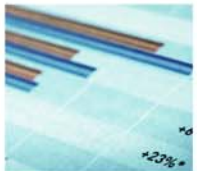
Requirements for Medicare FFS ACOs (cont'd)

- Specialists generally need not be restricted to one ACO (though perhaps exceptions are in order for cardiologists, oncologists, or other “quasi-PCP-gate-keeper” specialists)
- Hospitalists are key component, to minimize unnecessary inpatient days
- If ACO or its providers are at financial risk, ideally 50,000+ assigned members



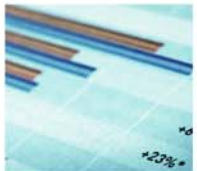
Key Issues with Medicare FFS ACOs

- To earn Shared Savings incentive payments, ACO will be expected to meet Medicare performance standards measuring the quality of care furnished
- ACOs will be expected to improve the quality and cost of care furnished over time by meeting increasingly stricter quality and cost benchmarks (to be adjusted every 3 years)
- ACOs need to have the ability to capture and report data, at the group and individual provider level, relating to measures necessary to evaluate the quality of care furnished
- If already highly cost-effective historically, will ACO providers be financially penalized by being held to a higher benchmark standard?



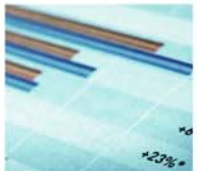
Key Issues With Medicare FFS ACOs (cont'd)

- ACO providers are to be held “accountable” for the quality, cost, and overall care of Medicare FFS beneficiaries assigned to ACO (including aging “Baby Boomers”) but (i) no channelling financial incentives or other restrictions to prevent beneficiaries receiving services from non-ACO providers and (ii) apparently no access to Medicare Part D Prescription Drug Program data
- How will Medicare beneficiaries be assigned to an ACO? E.g., Dartmouth/Brookings model where patients are empirically assigned to a provider based on the patient’s historical care patterns (using two years of claims data)?



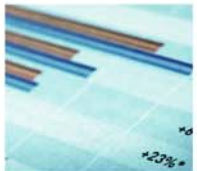
Some Significant Unanswered Questions About Medicare FFS ACOs

- Will CMS risk-adjust benchmark reporting to avoid penalizing ACOs that treat very ill patients?
- Will beneficiaries retain freedom of choice in selecting their individual physicians in an ACO?
- How will beneficiaries be assigned to the ACO (e.g., prospective assignment)? Will they even know they are in an ACO? Can they opt out?
- How will CMS ensure that ACOs have sufficient capital to fund EHR and be able to provide real-time data required by the ACO contract?



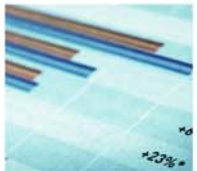
Medicare Payment Advisory Commission (“MedPAC”) Provides Comments to CMS

- MedPAC letter to CMS on November 22, 2010 critiqued FFS Shared Savings ACO Payment Model
- Argued for “Two-Sided Risk Model” (e.g., various forms of capitated or quasi-capitated risk-sharing payment models)
- Medicare Beneficiaries need to receive disclosure and “opt-out” right; suggested possible ways to get beneficiaries “on board” with their ACO
- Suggested quality metrics



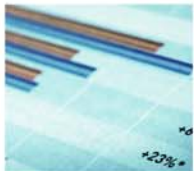
MedPAC's View on Two-Sided Risk Model

- Solving the “random variation” problem (which otherwise can result in wasteful spending by CMS) requires the “Two-Sided Risk Model”
- Could be in addition to (and eventually replace) “upside only” model under PPACA
- If PPACA § 3022 ACO provisions do not allow for “Two-Sided Risk Model,” then CMS should use CMMI to introduce the concept



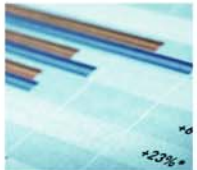
MedPAC Critique of FFS Shared Savings Model: Problem of Random Variation

- Step 1 of Analysis: MedPAC notes a problem with “upside-only” model: random variation invites overutilization and waste
 - Groups of 5,000+ Medicare Beneficiaries
 - 25% of all such groups have year-to-year random variation of 2% of costs
 - Random variation is wasteful in “upside-only” model – some ACOs may receive shared savings without merit
- Step 2 of Analysis: Fix for random variation problem is establishing a “threshold”
 - For example, little or no participation in Shared Savings of less than 2%



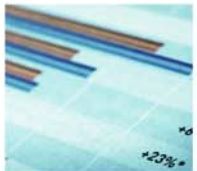
MedPAC: How To Solve The Problem of Random Variation (cont'd)

- Step 3 of Analysis: Adding a threshold changes incentives/disincentives for marginal ACOs, could create perverse incentives for additional services
- Step 4 of Analysis: Introduction of “downside risk” puts the brakes on ACO incentive to overutilize services in order to generate FFS revenue when potential for Shared Savings is deemed lost



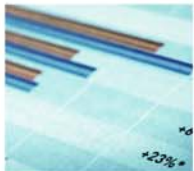
MedPAC's Comments on Medicare Beneficiary Involvement

- CMS should explore possibilities to garner acceptance of ACOs
 - Perhaps Medicare Beneficiaries in an ACO should participate in the shared savings?
 - Reduced Medicare copayments for beneficiaries who utilize ACO-contracted provider network?
 - Direct CMS payments to beneficiaries, so they share in any shared savings?



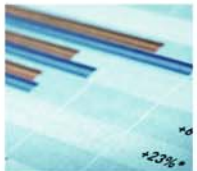
The Future of Medicare Payment Reform

- Medicare reimbursement reform is moving from ACO Shared Savings Program (required by 1/1/2012) towards:
 - Bundled Payments/Case Rates for “Episode Treatment Groups” (“ETGs”)
 - Partial (or perhaps full) Capitation (growing healthcare industry consensus favoring “Two-sided Risk”)



The Future of Medicare Payment Reform (cont'd)

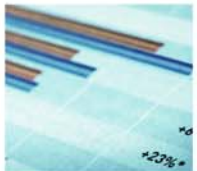
- PPACA authorizes Secretary of HHS to utilize specified payment models other than Shared Savings Program:
 - Partial Capitation, where ACO is at financial risk for some, but not all, of Part A and Part B services
 - But the Secretary of HHS may substitute “any payment model that the Secretary determines will improve the quality and efficiency of health care delivery”; CMMI funded to create new payment models
- Estimated 1/3 of cost is “waste” (“expenditure that, if eliminated, would not reduce quality”)



The Future of Medicare Payment Reform (cont'd)

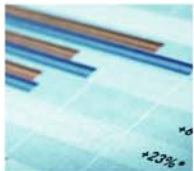
- **Relevant Demonstration Projects**
 - PPACA requires CMS to create a national pilot program on payment bundling for Medicare by Jan. 1, 2013

 - PPACA establishes various Medicaid demonstration projects related to ACO development
 - Bundled payment demonstration in up to 8 states
 - Global capitated payment structure for safety-net hospitals in 5 states
 - Pediatric ACO demonstration project with shared savings payments
 - Emergency psychiatric services demonstration project in up to 8 states



Bundled Payments/Episodes of Care

- One payment for an episode of care (e.g., cardiovascular bypass surgery, knee replacement), combining hospital/physician and other services
- Secretary of HHS is required to establish a pilot program for integrated care during an episode of care occurring around a hospitalization
- Episode of care (aka “Episode Treatment Group” or “ETG”):
 - 3 days prior to hospitalization
 - During length of inpatient stay
 - 30 days post discharge



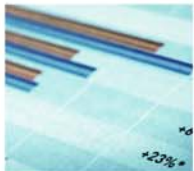
Medicare Bundled Pilot Program

- The Secretary of HHS must select up to 10 conditions and must consider the following applicable services:
 - Inpatient acute care
 - Physician care in and out of a hospital
 - Hospital outpatient care
 - Post-acute care
- Reimbursement for all services included in treating the condition during the episode of care:
 - Sole payment (i.e., no separate unbundled fee-for-service payments)
 - Patient assessment and quality measures
- No specification from CMS on how ACOs are to share bundled payments with those providing health care (must be negotiated by ACO under ACO-provider subcontracts)



Bundled Payment Key Definitions

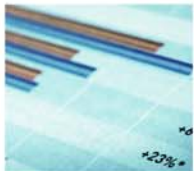
- **Components** are the various services (physician, hospital, imaging, physical therapy) & supplies (drugs, durable medical equipment, etc.) utilized in the delivery of care across some or all
- **Episode of Care** refers to all components that occur as a result of a specific acute event such as a CABG or knee-replacement. Variation what constitutes the start and end of the Episode.
- **Medical Episode Grouping** refers to a specific retrospective grouping of components which can be associated with a specific health condition or emergent event. Variable rules can be applied to define start & end date.



Bundled Payment Key Definitions (cont'd)

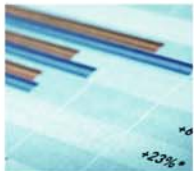
- **Bundle of Services** is a prospective statement of what components are included in a discrete healthcare deliverable to define a boundary around a package or offering.
- **Bundled Payment** Contractual agreement to pay certain fee for a specific Bundle of Services. A single Provider receives the payment but may providers fulfill different components.
- **Chronic Care Model** Long-term management of a patient through all episodes and all Providers with the goal of maximizing quality of life, minimizing acute episodes.

Source: Pendulum Healthcare



Partial Capitation

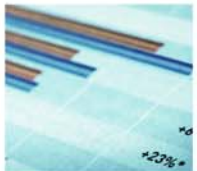
- Partial Capitation (“Medicare Advantage Lite”) would:
 - Cover all or part of (e.g., physician only) health care costs for a given population of patients over a time period
 - Eliminate volume-based payment incentives
 - Create a budgeted cost/utilization and associated payment methodology for ACOs
- Payments would be risk-adjusted (e.g., adjusted for age, health status), but unlike the ACO “shared savings” program there would be significant downside financial risk under Partial Capitation
- Minimizes antitrust price-fixing risk among physician competitors if agree to share capitated or similar financial risk



As Ideal ACO Payment Model?

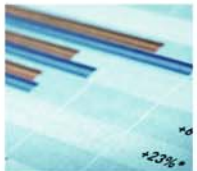
- Primary Care: Capitation (Risk Adjusted)
- Emergency/Urgent Care: FFS with higher copayment, patient education
- Specialist Care: Bundled Payments (Risk/Severity Adjusted)

Source: Goldsmith, J., “Accountable Care Organizations: The Case for Flexible Partnerships Between Health Plans and Providers” Health Affairs (January 2011)



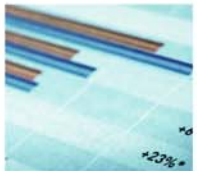
ACO Threshold Decisions

- Providers should immediately consider restructuring existing managed care integrated health care delivery systems (e.g., PHOs, contractual Hospital/Medical Group/IPA risk-sharing affiliations) into ACOs that can enter into risk contracts with private health plans
- HMOs and Insurers (including self-funded employers/union trust funds) will likely want to contract with ACOs delegate to shift more risk as well as to “administrative services,” due to cost pressures from (i) end of preexisting condition exclusion; (ii) mandated benefits expansion, (iii) new 85/15 and 80/20 minimum medical-loss ratio (“MLR”) requirements under the PPACA, and (iv) increasing pressure to restrain premium increases.



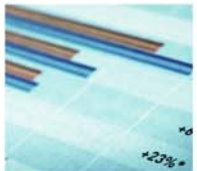
Payor Collaboration Issues: Benefit Design

- **HMO model**
 - HMO delivery system product with coverage limited to contracted provider network
 - Does the HMO product have sufficient market penetration to meet the critical mass requirements of the ACO model (50,000+ lives)?
 - Medicare Advantage experiencing upswing in popularity among physicians have proven ability to manage Medicare services on a cost-effective basis
- **PPO model**
 - Use of PPO product design with reduced copayments or coinsurance for the use of ACO network providers
 - Is a preferred tier of providers within an existing preferred network permitted under state insurance law?



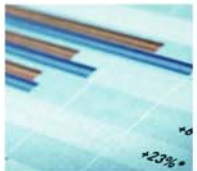
Spectrum of Payor-ACO Payment Structure

- “Risk Light”: simple gain sharing based on medical claims expense with withhold upside
- Risk Light Plus: in addition to gainsharing around medical claims expense, include quality improvement initiatives – e.g., readmission rate for members assigned to ACO physicians
- Shared risk: sharing of gains and losses based on either medical expense target or split overall performance
- Full risk: provider organization assumes full risk for members assigned to ACO-affiliated based PCPs; ACO assumes all administrative functions



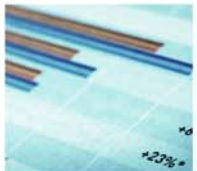
Example of Successful Non-Medicare “Virtual ACO” Collaborative Model

- Blue Shield of California, Catholic Healthcare West, Hill Physicians (2010-11)
 - Created ACO to manage the care of 40,000 CalPERS members
 - Goal: Keep plan health care costs flat in 2010
 - Utilized existing benefit product
 - Blue Shield HMO benefit product
 - Members with existing primary care physicians affiliated with Hill Physicians
 - Parties said biggest challenge centered around data creation, sharing, and access
 - Results: First year resulted in better care and millions of dollars in savings
 - Zero percent premium increase for 2011



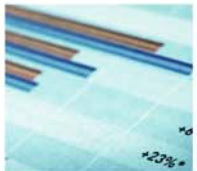
Key Legal Issues Related to Payor-ACO Payments

- Federal Antitrust Laws (Sufficient financial integration or clinical integration?)
- Representative State Law Issues: HMO/Insurance/TPA Licensing Laws and Corporate Practice of Medicine Laws



Antitrust

- Can ACO participants jointly contract with payors?
 - Single Entity
 - Financial Integration
 - Clinical Integration
 - Exclusivity (more than 20-30% of competing providers bound exclusively to ACO in defined geographic market?)
- Price-fixing risk in negotiating rates with private payors, including Medicare Advantage Plans
- Not an issue with Medicare FFS ACO, because Medicare sets FFS payments and no negotiation by ACO providers



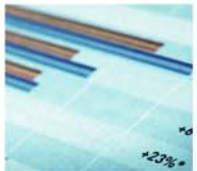
ACOs & Antitrust: Clinical Integration

- If providers in ACO are not competitors or are considered a single entity, they are incapable of violating price-fixing prohibition
- If providers in an ACO are competitors and are not considered a single entity, then they must demonstrate sufficient financial integration or clinical integration through which they can operate as a single entity for antitrust purposes
- If insufficiently integrated, ACO must use unwieldy and ineffectual “messenger model”



ACOs & Antitrust (cont'd)

- **Financial Integration**
 - Capitation
 - Percentage of premium
 - High withholds
 - Bundled payments
- **Clinical Integration**
 - If competing physicians are not financially integrated (i.e., FFS with upside only), must be clinically integrated
 - Four FTC advisory opinions; three favorable



ACOs & Antitrust (cont'd)

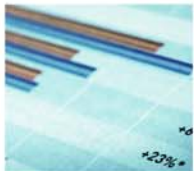
PPACA ACO REQUIREMENTS COMPARED TO CHARACTERISTICS OF PROVIDER NETWORKS WHOSE CLINICAL INTEGRATION PROGRAMS THE FTC HAS REVIEWED AND APPROVED IN ADVISORY OPINIONS			
ACO Requirements	MedSouth	GRIPA	Tri-State
Accountable for quality, cost and overall care of patients	Yes	Yes	Yes
Formal legal structure that allows organization to receive and distribute payments	Yes	Yes	Yes
Includes sufficient number of primary care physicians for number of patients	Yes	Yes	Yes
Leadership and management structure that includes clinical and administrative systems	Yes	Yes	Yes
Reports on quality, utilization and clinical processes and outcomes	Yes	Yes	Yes
Defines processes to promote evidence-based medicine, reports on quality and cost measures, and coordinates care, such as through use of telehealth, remote patient monitoring, and other technologies	Yes	Yes	Yes
Meets patient-centeredness criteria specified by HHS	TBD	TBD	TBD

The FTC has considered other factors, as well, in its evaluation of clinical integration programs to achieve procompetitive efficiencies that will benefit patients/consumers.



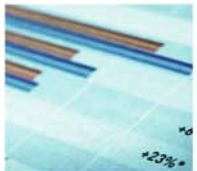
ACOs & Antitrust (cont'd)

ADDITIONAL FACTORS RELEVANT TO FTC ANALYSIS OF CLINICAL INTEGRATION PROGRAMS			
FACTOR	MedSouth	GRIPA	Tri-Health
Use of health information technology	Yes	Yes	Yes
Physician investment of capital	Yes	Yes	Yes
Non-exclusive contracting by physician members	Yes	Yes	Yes
Joint contracting ancillary to expected procompetitive efficiencies	Yes	Yes	Yes
Enforcement mechanisms to ensure member compliance	Yes	Yes	Yes



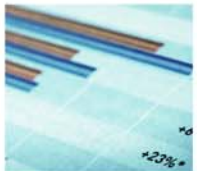
Representative State Law Issues

- Corporate Practice of Medicine
- HMO/Insurance/Managed Care Contracting Laws



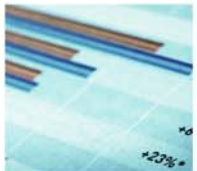
Representative State Law Issues: Corporate Practice of Medicine

- Most states still have laws that prohibit, to varying degrees, the “corporate practice of medicine” (“CPOM”), which generally prevent unlicensed lay entities from employing physicians or otherwise contracting with physicians to furnish medical care
- CPOM laws may limit the flexibility of physicians and non-physicians to structure ownership and employment arrangements of an ACO unless licensed as a managed care organization or hospital may employ physicians under state CPOM law.



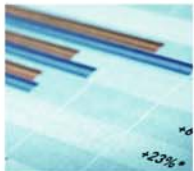
Representative State Law Issues: Corporate Practice of Medicine (cont'd)

- Some states with strong CPOM laws (e.g., California, Nevada, and Texas) even prohibit hospitals from employing physicians, but have laws permitting nonprofit “medical foundations” to engage physicians (e.g., in medical group) indirectly to provide medical care
- “Friendly Physician” or “Management” models in CPOM states will require careful regulatory analysis to minimize regulatory risk



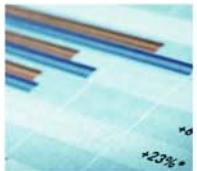
HMO/Insurance/Managed Care Licensing Laws

- National Association of Insurance Commissioners (“NAIC”) determined in 1990s that a health care provider receiving capitated-type payments assumes insurance-type financial risk
- In most states, capitation is permissible under state insurance/HMO law for state-licensed HMO’s “downstream” providers, within the scope of their medical/health licensure, for services provided to that HMO’s members



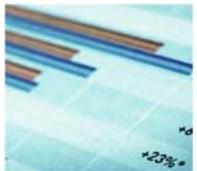
HMO/Insurance/Managed Care Licensing Laws

- **Capitated or Other “Downside Risk” Payments?**
 - In a number of states (e.g., California, Colorado, Illinois, New Jersey, New York, Ohio and Pennsylvania) an ACO is prohibited from assuming capitated or other substantial financial risk, unless the ACO is licensed by the state to assume such financial risk or falls within an exception.
- **ACO that direct contracts with self-funded ERISA plan is not shielded from state insurance/HMO licensure and regulation by ERISA preemption, which applies only to plan itself. [See Hewlett-Packard Co. v. Barnes, 571 F. 2d 502 (9th Cir 1978)]**
 - Congress could preempt state insurance/HMO laws for Medicare capitation, but PPACA does not appear to do so.



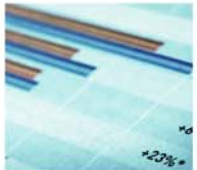
HMO/Insurance/Managed Care Licensing Laws (cont'd)

- Examples of State Managed Care Laws that May Apply to ACOs include:
 - California's Knox-Keene Act
 - Colorado's Division of Insurance Regulations
 - Florida's Definition of Fiscal Intermediary Service Organization
 - Illinois' PPO Regulations under the Health Care Reimbursement Reform Act of 1985
 - New Jersey's N.J. Stat. §§ 17:48H-1 et. seq.
 - Ohio's Rev. Stat. Chapter 1751
 - Pennsylvania's Department of Insurance Regulations



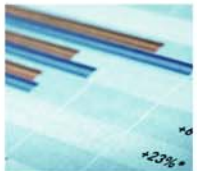
HMO/Insurance/Managed Care Licensing Laws (cont'd)

- Applicability of state insurance/HMO/managed care laws will depend on precise payment structure
 - Global capitation/percentage of premium
 - Capitation only for services that capitating provider is licensed to provide
 - Risk corridors (10-15% or 50%?)
 - FFS combined with withholds (10-15% or 50%+)
 - FFS with upside shared savings bonus (not regulated)
 - ACO contracts with private payor or Medicare Advantage Plan vs. self-funded employer



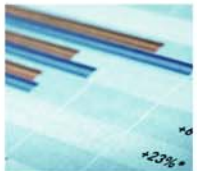
HMO/Insurance/Managed Care Licensing Laws (cont'd)

- In some states (such as California, Ohio, and New Jersey), providers that lack a state health plan license may not capitate or assume substantial financial risk other than under contract with a licensed HMO, and then only for services within scope of provider's licensure.
- In those states, an ACO may still engage in direct employer fee-for-service contracting as permitted by CPOM (including case rates and other bundled pricing) but is prohibited from being paid on a capitated basis or otherwise assuming substantial financial downside risk unless the ACO holds the required state HMO, PPO or insurance license.



HMO/Insurance/Managed Care Licensing Laws (cont'd)

- Must review state insurance/HMO managed care law carefully before structuring ACO
- Note: If ACO is not a licensed health plan and is delegated TPA functions (e.g., claims adjudication), ACO may be required to obtain a state third party administrator (“TPA”) license





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A “Straw Model” for Intra-ACO Funds Flow

David L. Klatsky
McDermott Will & Emery LLP

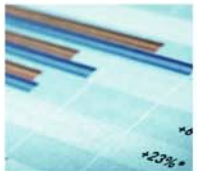
March 29, 2011

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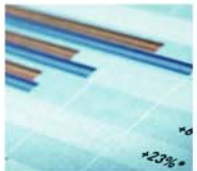
FUNDS FLOW “STRAW MODEL”

- One possible model for ACO provider compensation
- Flexibility is key
- Assumes that ACO participants include hospitals, primary care physicians and specialists



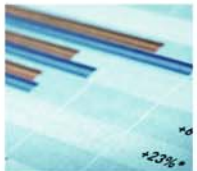
REGULATORY HURDLES

- Kickback Laws
- Self-referral Laws
- CMP Law
- Corporate Practice of Medicine
- Tax Exemption Concerns



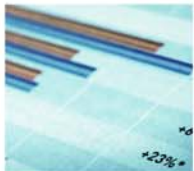
OBJECTIVES OF COMPENSATION MODEL

- Encourage value-driven, rather than volume-driven, care
 - Contain cost
 - Improve quality
 - Improve patient and caregiver experience
- Transparent and fair
- Simple



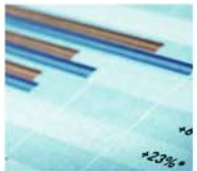
RULES OF THE ROAD: “STRAW MODEL”

- Establish over-all budget for population medical expense
- Establish pools within over-all budget to foster accountability at each level of care
 - PCP professional fees
 - Specialist professional fees
 - Ancillaries
 - Outpatient pharmacy
 - Outpatient services
 - Outpatient diagnostic services
 - Acute/post-acute care



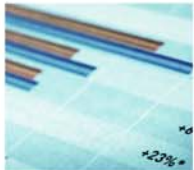
RULES OF THE ROAD

- Ancillaries pool
 - Physician-owned ancillaries
 - Ambulance
 - DME
 - Home Health
 - Other



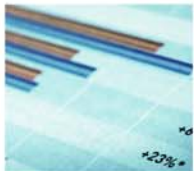
RULES OF THE ROAD

- Outpatient services pool
 - ER
 - Surgery
 - Outpatient rehab
 - Radiation therapy
 - Other



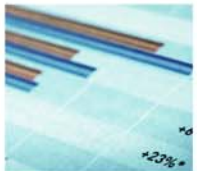
RULES OF THE ROAD

- Outpatient Diagnostic Services
 - Lab
 - Imaging
 - Pathology
 - Other



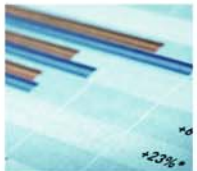
RULES OF THE ROAD

- Acute/post-acute pool
 - Hospital
 - SNF
 - Inpatient rehab



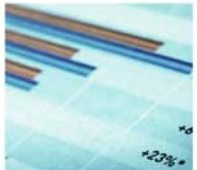
RULES OF THE ROAD

- Actual costs charged against pools to determine surplus/deficit
- Both in-network and out-of-network costs
- Must have a net surplus over-all
- If desired, surpluses in pools can be used to offset deficits
- Shared savings bonuses allocated to applicable pools



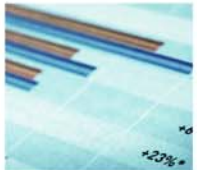
RULES OF THE ROAD

- Individual providers forfeit distribution if they fail to meet quality benchmarks
- All undistributed funds in each pool are reallocated to qualifying providers in that pool
- ACO will take corrective action against providers that continuously miss benchmarks



KEY ASSUMPTIONS

- The assigned population will be severity-adjusted
- PCP performance will be measured based on assigned patients
- Specialist performance will be measured based on unique patient contacts
- Hospital performance will be measured based on % of over-all acute/post-acute spend
- A percentage of any surpluses will be retained to fund ACO infrastructure costs

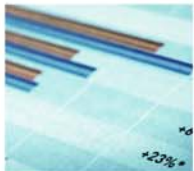


ALLOCATION TO COMPENSATION POOLS

Medical Expense Pool

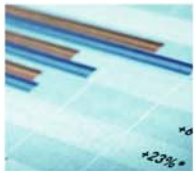
Allocation of Surplus

	Hospitals	PCPs	Specialists
PCP Professional Fees	0%	100%	0%
Specialist Professional Fees	0%	0%	100%
Outpatient Ancillaries	0%	50%	50%
Outpatient Pharmacy	33%	33%	33%
Outpatient Services	33%	33%	33%
Outpatient Diagnostics	0%	50%	50%
Acute/Post-Acute	33%	33%	33%

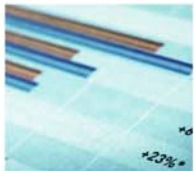
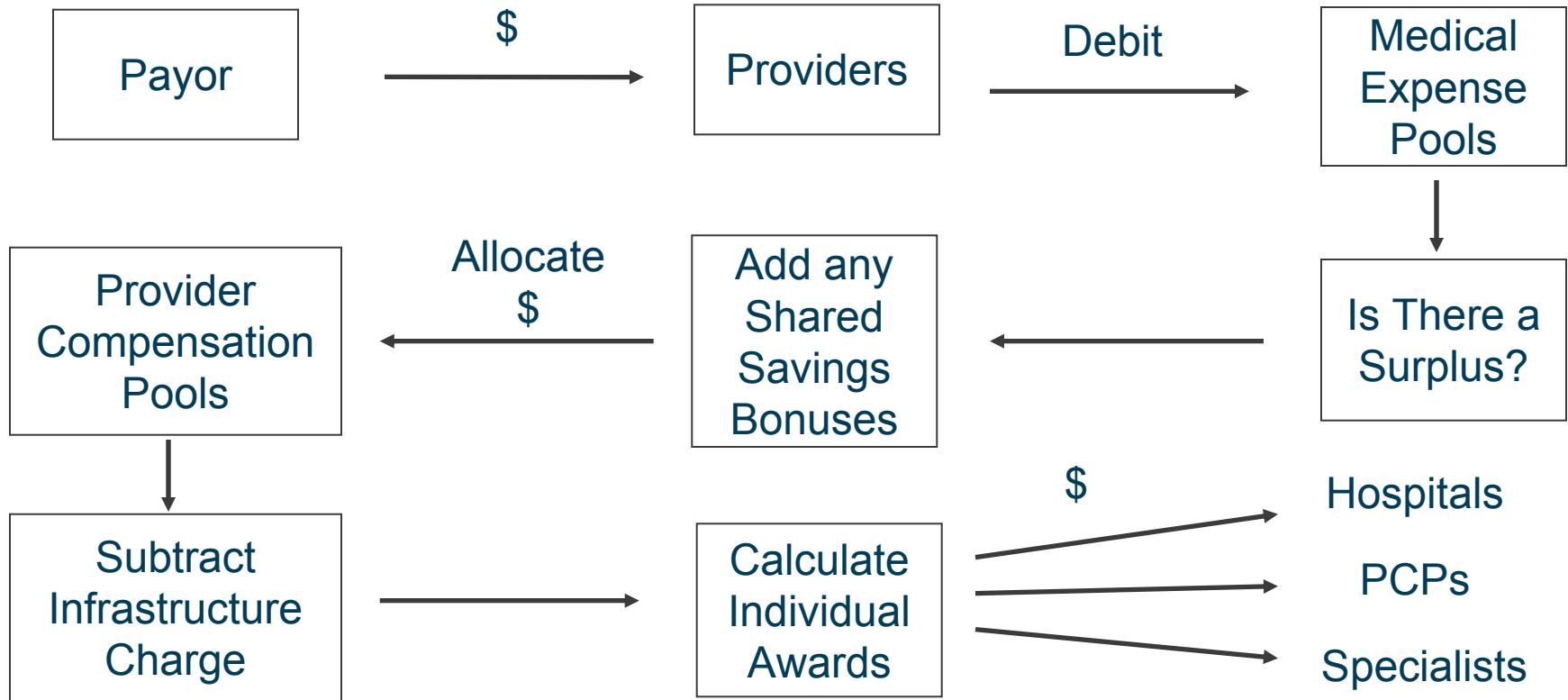


DIVISION OF PROVIDER COMPENSATION POOLS

- 50% based on volume
 - Weighted number of PCP assigned patients
 - Weighted number of Specialist unique patient contacts
 - Percentage of actual expenditures for acute/post-acute services
- 50% based on value
 - Achievement of quality benchmarks
 - Adherence to evidenced-based clinical protocols
 - Participation in care coordination activities
 - Patient/caregiver satisfaction

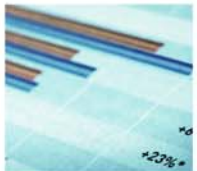


ACO FUNDS FLOW



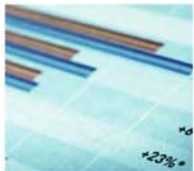
SURPLUS CALCULATION

<u>Pool</u>	<u>Target Expenditure</u> <u>(\$000s)</u>	<u>Actual Expenditure</u> <u>(\$000s)</u>	<u>Surplus/Deficit</u> <u>(\$000s)</u>
PCP	\$ 5,000	\$ 7,000	(\$ 2,000)
Specialist	\$15,000	\$12,000	\$ 3,000
Ancillary	\$ 4,000	\$ 3,700	\$ 300
Pharmacy	\$ 1,000	\$ 700	\$ 200
OP Services	\$ 8,000	\$ 9,000	(\$ 1,000)
OP Diagnostics	\$ 5,000	\$ 6,000	(\$ 1,000)
Acute/Post-Acute	\$50,000	\$40,500	<u>\$10,500</u>
		NET SURPLUS:	\$10,000



FUNDING OF PROVIDER COMPENSATION POOLS (\$000s)

<u>POOL</u>	<u>SURPLUS/DEFICIT</u>	<u>PCP</u>	<u>SPECIALIST</u>	<u>HOSPITAL</u>
PCP	(\$2,000)	\$0	\$0	\$0
Specialist	\$3,000	\$0	\$3,000	\$0
Ancillaries	\$300	\$100	\$100	\$100
Pharmacy	\$200	\$100	\$100	\$0
OP Services	(\$1,000)	\$0	\$0	\$0
OP Diagnostics	(\$1,000)	\$0	\$0	\$0
Acute/Post-acute	\$10,500	<u>\$3,500</u>	<u>\$3,500</u>	<u>\$3,500</u>
		\$3,700	\$6,700	\$3,600



PCP DISTRIBUTION

ALLOCATED SURPLUS (less 10% infrastructure charge): \$3,330,000

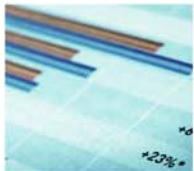
PCP	Assigned Patients	% Total	Maximum Distribution	Individual PCP Performance Metrics				Qualifying Categories	%	50% Volume Payout	50% Perform Payout	Total Payout
				Quality	Adherence to Protocols	Care Coordination	Patient/ Caregiver Satisfaction					
A	2,000	40%	\$1,332,000	x	x	x		3	75%	\$660,000	\$449,500	\$1,159,500
B	1,000	20%	\$666,000	x	x	x	x	4	100%	\$333,000	\$333,000	\$666,000
C	500	10%	\$333,000		x		x	2	0%	\$0	\$0	\$0
D	1,500	30%	\$999,000	x				1	25%	\$499,500	\$124,875	\$624,375
Totals	5,000	100%	\$3,330,000	3	3	2	2	10		\$1,498,500	\$957,375	\$2,449,875
DOLLARS TO BE REDISTRIBUTED:										\$166,500	\$707,625	



SPECIALIST DISTRIBUTION

ALLOCATED SURPLUS (less 10% infrastructure charge): \$6,030,000

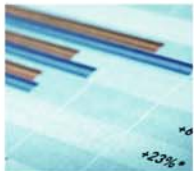
Specialist	Unique Patient Contacts	% Total	Maximum Distribution	Individual Specialist Performance Metrics				Qualifying Categories	%	50% Volume Payout	50% Perform Payout	Total Payout
				Quality	Adherence to Protocols	Care Coordination	Patient/ Caregiver Satisfaction					
A	75	25%	\$1,507,500	x	x			2	50%	\$753,750	\$376,875	\$1,130,625
B	100	33.3%	\$2,007,990	x		x	x	3	75%	\$1,003,995	\$752,996	\$1,756,991
C	100	33.3%	\$2,007,990	x	x	x	x	4	100%	\$1,003,995	\$1,003,995	\$2,007,990
D	25	8.4%	\$506,520		x	x		2	0%	0%	0%	0%
Totals	300	100	\$6,030,000	3	3	3	2	11		\$2,761,740	\$2,133,866	\$4,895,606
DOLLARS TO BE REDISTRIBUTED:										\$253,260	\$881,134	



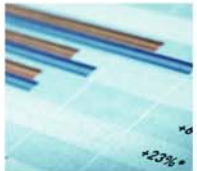
HOSPITAL DISTRIBUTION

ALLOCATED SURPLUS (less 10% infrastructure charge): \$3,240,000

HOSPITAL NAME	ACTUAL EXPENDITURE	% Total	Maximum Distribution	Individual Hospital Performance Metrics				Qualifying Categories	%	50% Volume Payout	50% Perform Payout	Total Payout
				Quality	Adherence to Protocols	Care Coordination	Patient/ Caregiver Satisfaction					
A	\$20,000,000	50%	\$1,620,000	x	x	x		3	75%	\$810,000	\$807,500	\$1,417,500
B	\$10,000,000	25%	\$810,000	x	x		x	3	75%	\$405,000	\$303,750	\$708,750
C	\$10,000,000	25%	\$810,000	x		x		2	50%	\$405,000	\$202,500	\$607,500
Totals		100%	\$3,240,000	3	2	2	1	8		\$1,620,000	\$1,113,750	\$2,733,750
DOLLARS TO BE REDISTRIBUTED:										\$ 0	\$506,250	



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Business Implications Of Two-Sided Risk Contracts

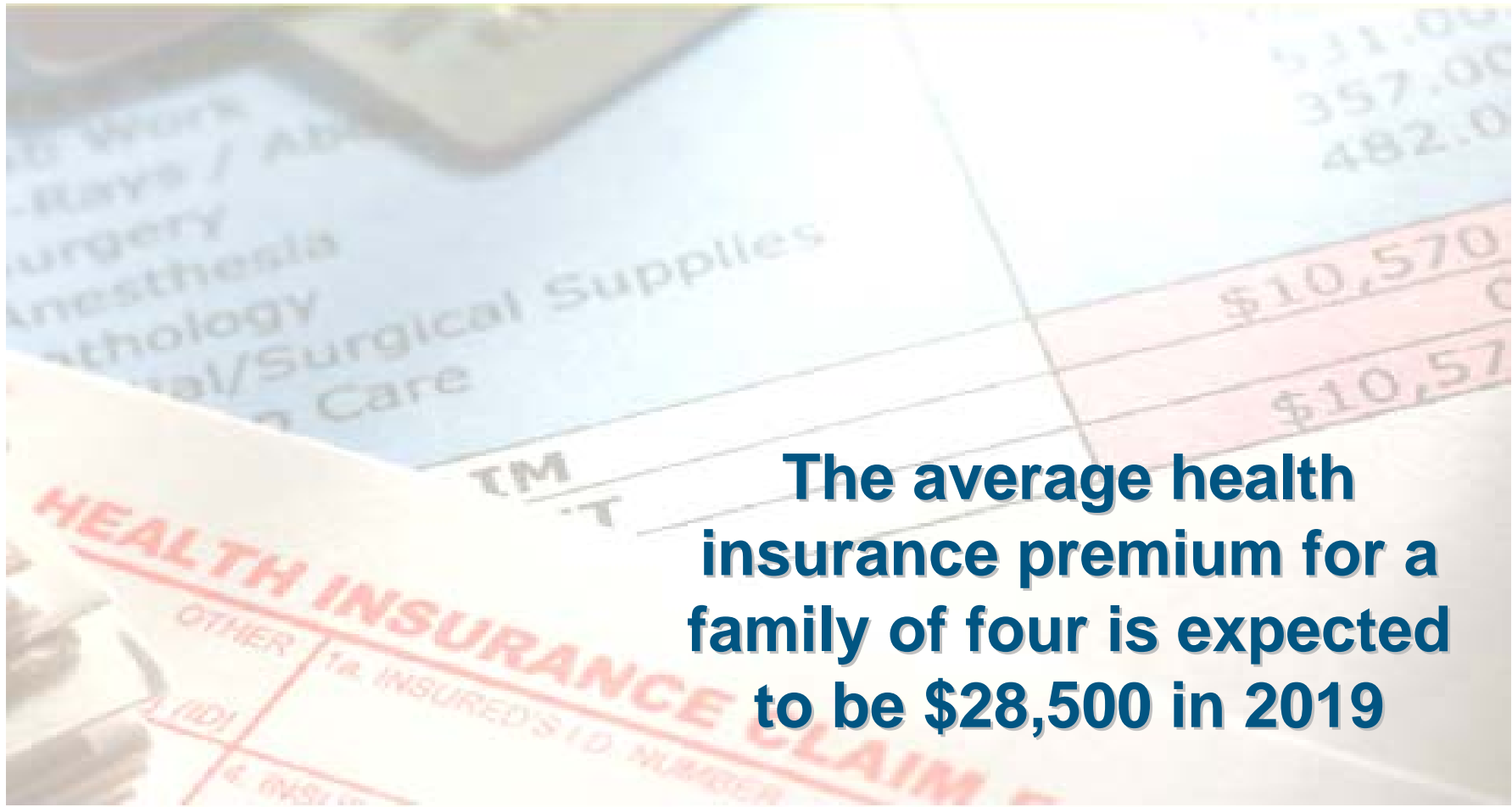
Peter Boland, PhD
Managing Partner
Polakoff Boland

March 29, 2011

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Unsupportable Cost Trends



The average health insurance premium for a family of four is expected to be \$28,500 in 2019



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Common Sense Questions

1 How will the pie be divided?

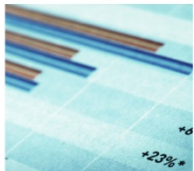
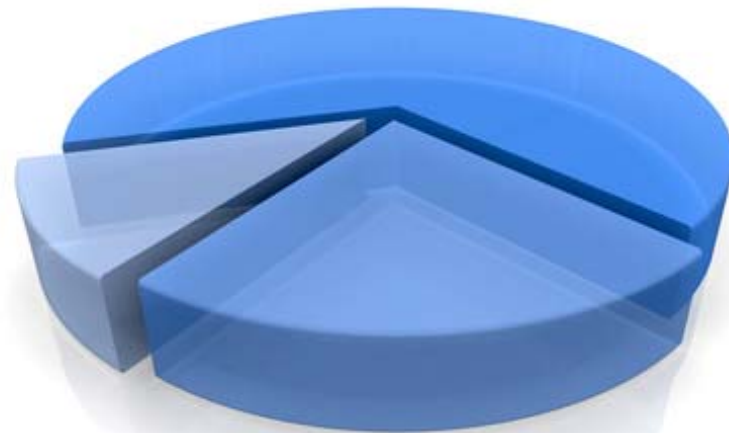
2 Who will divide up the pie?

3 How big is the pie?

4 How much does the pie cost?

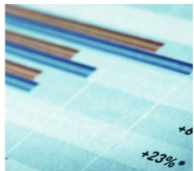
5 Who is paying for the pie?

6 How much are customers willing to pay?



Common Sense Answers

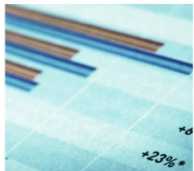
- | | | |
|---|--|---|
| 1 | How will the pie be divided? | Distribution formula based on capital investment, risk assumption, risk/cost management capability, performance bonus |
| 2 | Who will divide up the pie? | ACO leadership |
| 3 | How big is the pie? | Year 1 – less than the year before
Year 2 – less than the year before
Year 3 – less than the year before |
| 4 | How much does the pie cost? | Whatever providers can negotiate with payers based on purchaser price points |
| 5 | Who is paying for the pie? | Government, commercial insurers, employers and individuals |
| 6 | How much are customers willing to pay? | Medicare and Medicaid: less each year; Insurers: trend + 4%; Employers: CPI + 1% |



Simple Math



- 1 Revenue minus costs
- 2 Less payment for same services
- 3 Same services must be provided differently



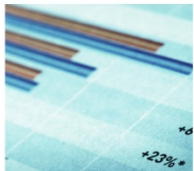
Simple Math Conclusions

1 Revenue minus costs

2 Less payment for same services

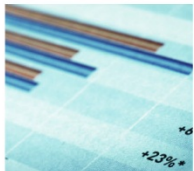
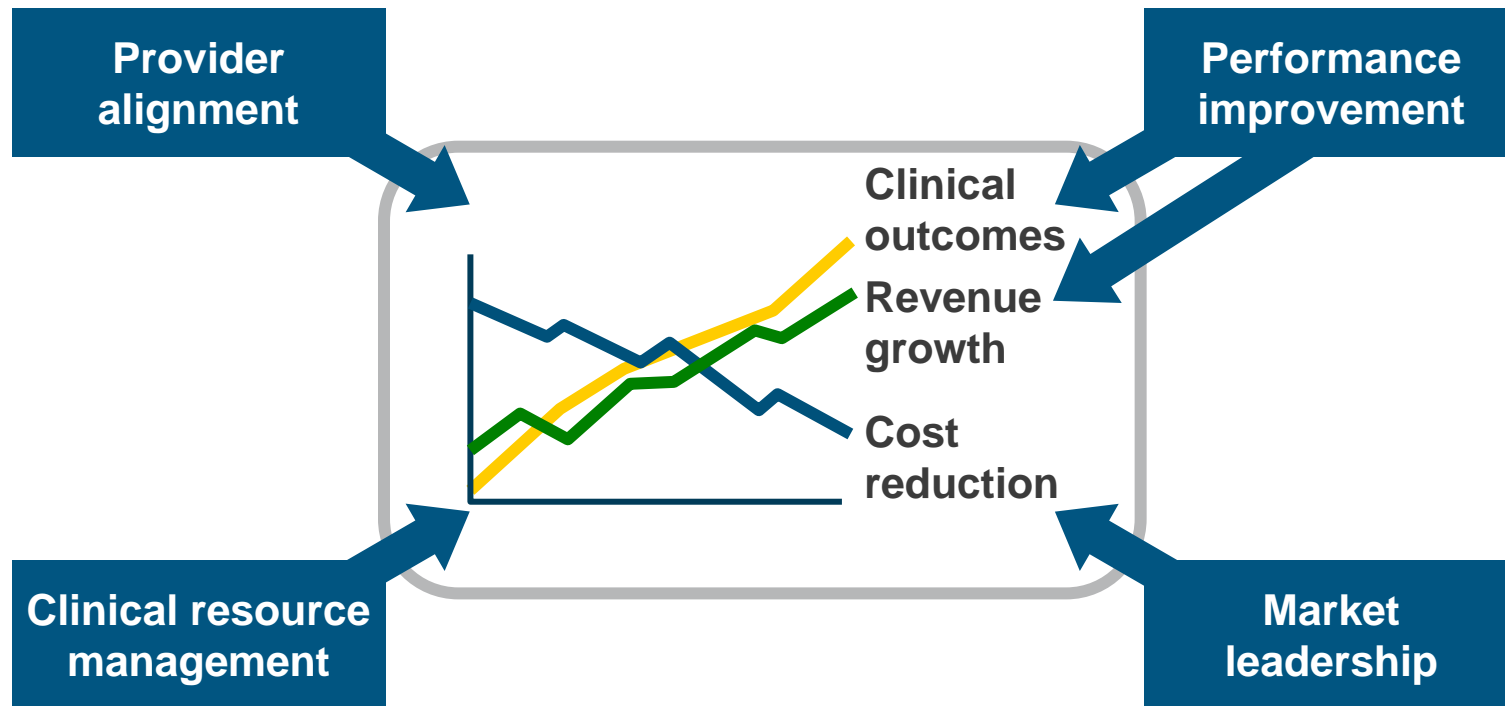
3 Same services must be provided differently

- Healthcare reform reimbursement will not grow with provider costs
- Spread between Medicare and commercial payment will narrow
- Providers cannot make up revenue loss on volume under current or expected rates
- Providers can make it up on: (1) quality bonuses, (2) higher per capita rates linked to better outcomes, (3) superior patient management skills, and (4) total cost reduction with capitated or global risk payments
- Providers must learn to break even on Medicare rates



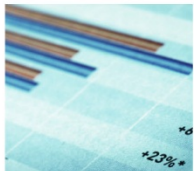
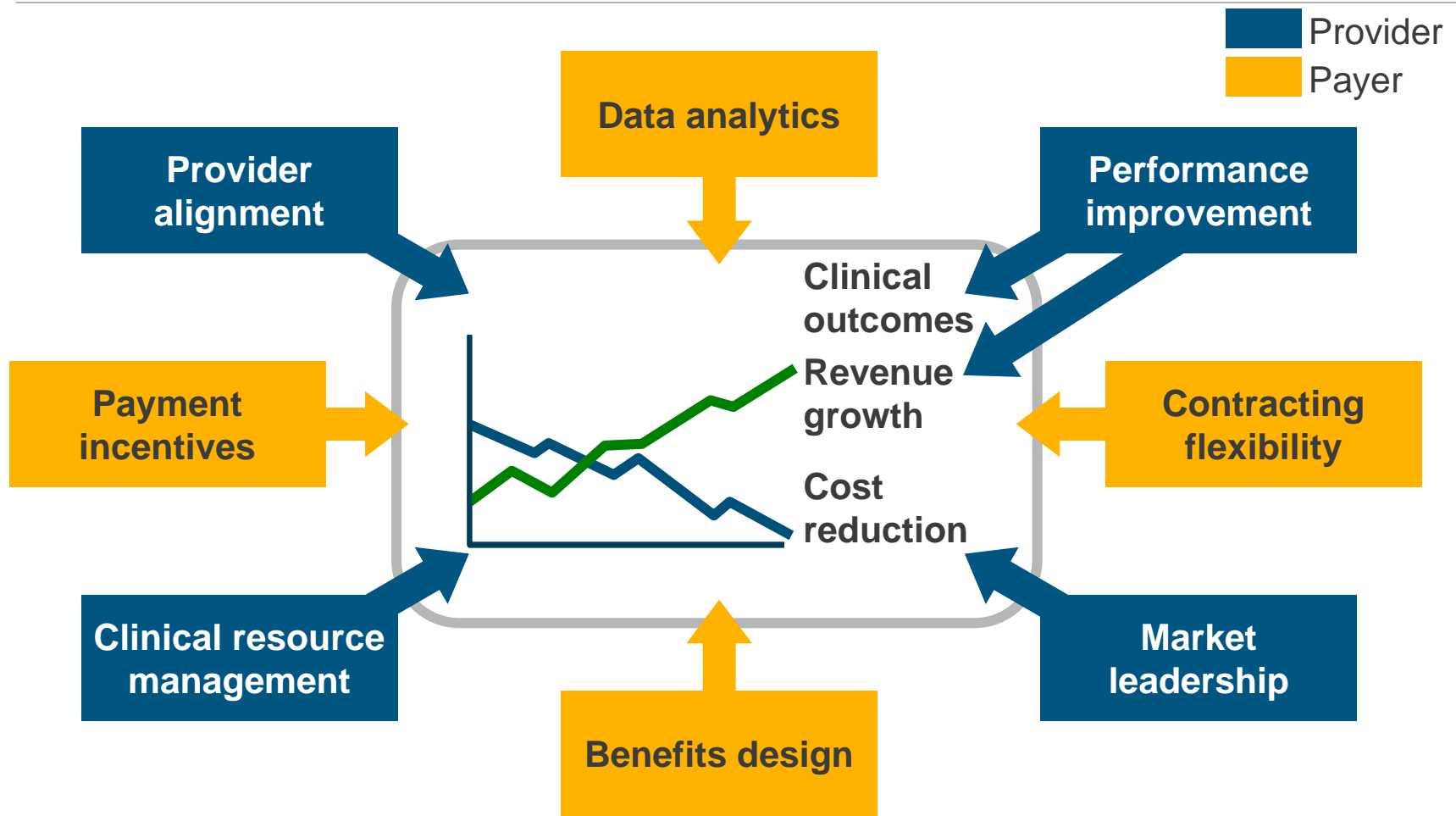
Provider/Payer Collaboration

■ Provider



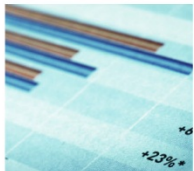
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Provider/Payer Collaboration

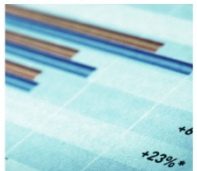


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Interdependent Wheel



Interdependent Wheel Elements

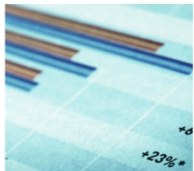


Risk/Reward Sharing Distribution Models

1. Reimbursement Model – FFS

Physician	FFS
Hospital	FFS, case rate
Payer	Traditional

Service	Medical groups	Hospital	Health plan	Employer
Institutional			100%	
Professional			100%	
Prescription drug			100%	

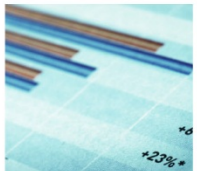


Risk/Reward Sharing Distribution Models, continued

2. Reimbursement Model – Hybrid

Physician	Capitation
Hospital	FFS
Payer	Traditional

Service	Medical groups	Hospital	Health plan	Employer
Institutional	37.5%	25%	37.5%	
Professional	100%			
Prescription drug	100%			

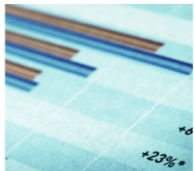


Risk/Reward Sharing Distribution Models, continued

3. Reimbursement Model – Mixed Risk

Physician	Capitation
Hospital	Partial risk
Payer	Traditional

Service	Medical groups	Hospital	Health plan	Employer
Institutional	50%	50%		
Professional	50%		50%	
Prescription drug	50%		50%	

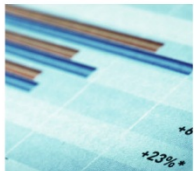


Risk/Reward Sharing Distribution Models, continued

4. Reimbursement Model – Shared Savings/Risk

Physician	Capitation/combined bottom line
Hospital	Partial risk/global risk/combined bottom line
Payer	Combined bottom line (conceptual)

Service	Medical groups	Hospital	Health plan	Employer
Institutional	33.3%	33.3%	33.3%	Negotiable
Professional	33.3%	33.3%	33.3%	Negotiable
Prescription drug	33.3%	33.3%	33.3%	Negotiable



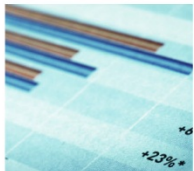
Risk/Reward Sharing Distribution Models, continued

5. Reimbursement Model – Shared Savings/Risk*

Physician	Capitation/combined bottom line
Hospital	Partial risk/global risk/combined bottom line
Payer	Combined bottom line (actual)

Service	Medical groups	Hospital	Health plan	Employer
Institutional	Each partner mutually responsible for costs in each care category	Each partner mutually responsible for costs in each care category	Each partner mutually responsible for costs in each care category	Premium guarantee in Year 1; lower premium costs Year 2 and 3
Professional				
Prescription drug				

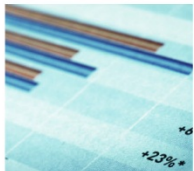
* Internal cell structure for a “combined bottom line” model will not be equally divided and will reflect multiple factors.



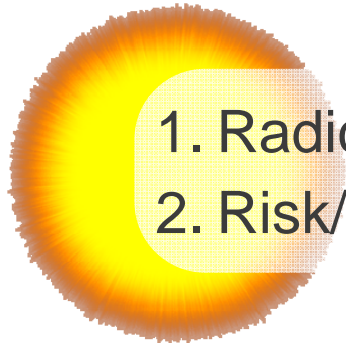
Distribution Elements

**Distribution of risk/
reward will be
a function of
elements such as ...**

- Goals of an organization (shared vision and commitment to cost/quality targets)
- Geographic-specific market conditions
- Financial and business needs of each stakeholder (to be explicitly addressed)
- Relative financials of each organization
- Capabilities of each organization to impact and manage cost and quality issues for each line of business (the “heavy lifting”)
- Amount of stake in the deal (“skin in the game”) for each organization
- Other tangible and intangible assets represented by each party
- Allocation to be revisited periodically



Payment Reform Dynamite



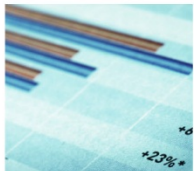
1. Radical cost reduction (some winners, some losers)
2. Risk/savings distribution (performance metrics)

Q

Who gets what for doing what?

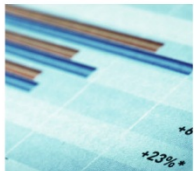
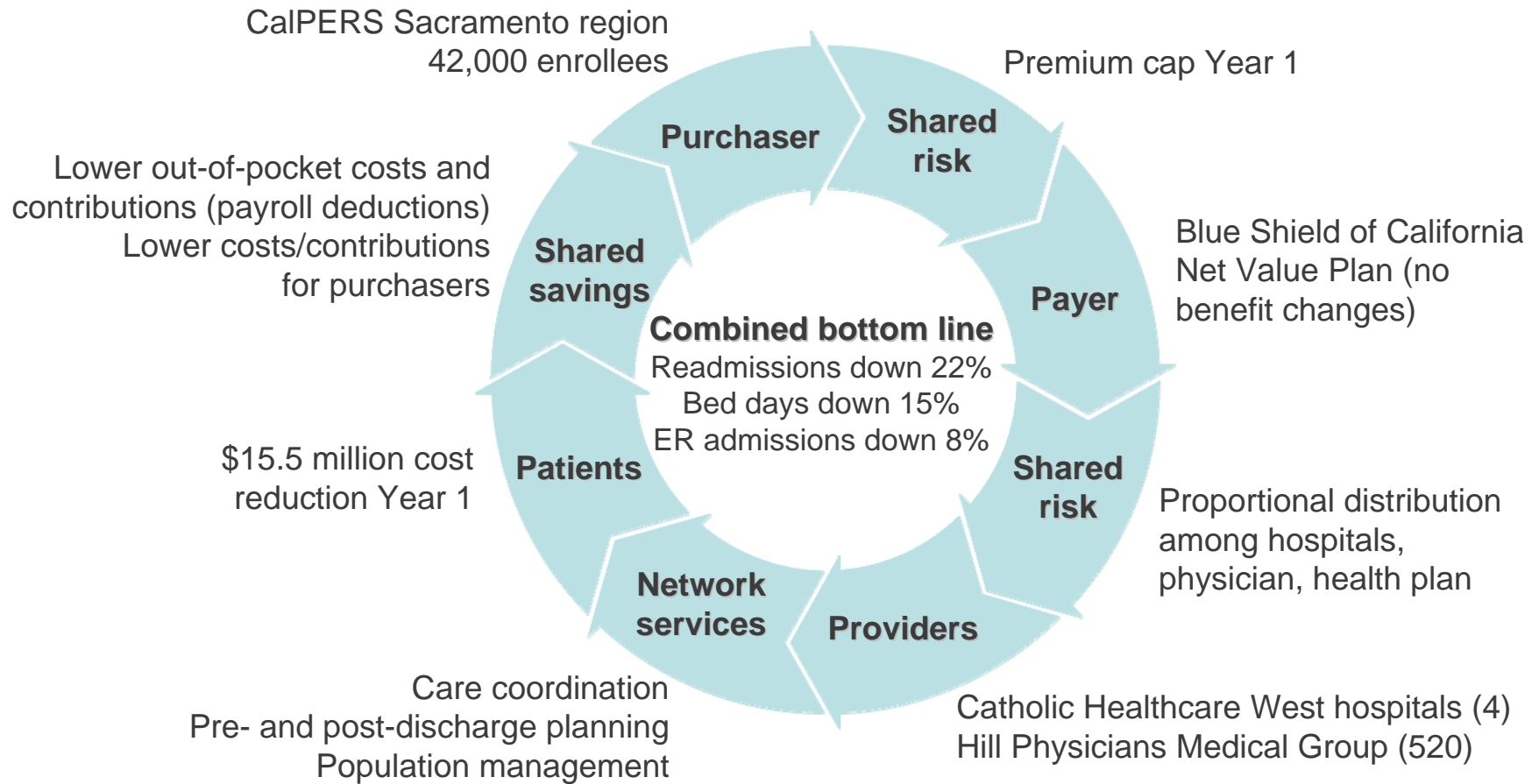
A

Best providers paid more for doing the right thing for patients, purchasers and payers



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Commercial Funds Flow: Combined Bottom Line



Multipartner ACO



Catholic Healthcare West

Lessons learned

- Medical groups, hospitals and payer must all work together – not two versus one
- Understand each party's issues, respect their vulnerabilities and solve them



Blue Shield

- Health plans must be transparent about pricing to build trust with providers
- Clinical and financial integration is the crux of collaboration between payers and providers



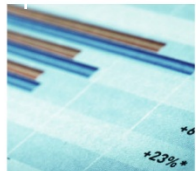
Hill Physicians

- Each partner has critical clinical and utilization data; transparency is key
- Four organization's divergent cultures must work hand-in-glove



CalPERS

- Zero trend in 2010 (same benefit structure)
- Bed days down 15%; readmissions down 22%; ER admissions down 7.6%; ALOS down 0.72 days



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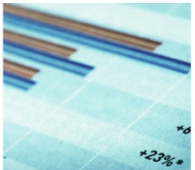
Changing Payer-Provider Corporate Culture

“If staff had done this, they would have been fired”

“Everyone wants money off the top, but you need to wait to get the savings”

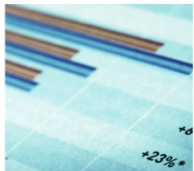
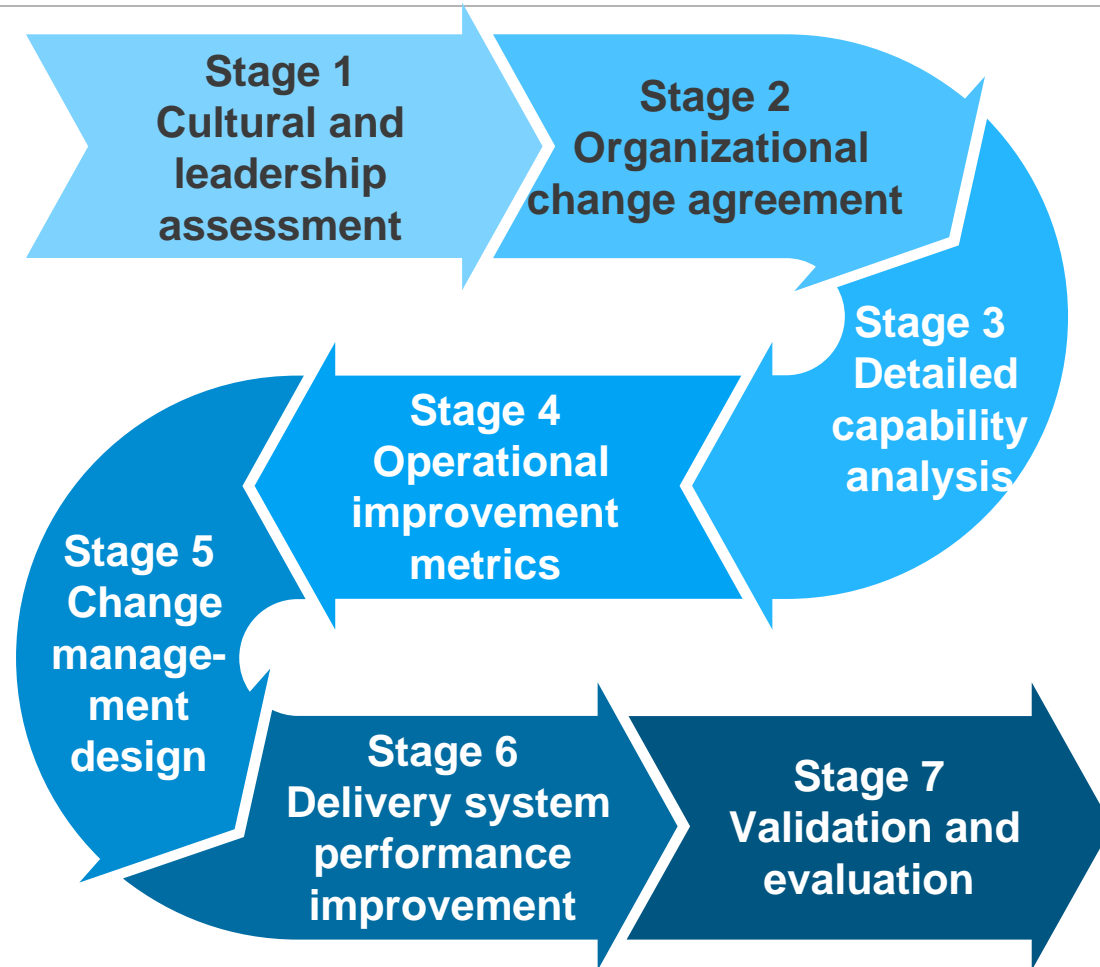
“At the end of the day, it comes down to people with feet on the ground – physicians, nurses, and techs”

“One person’s savings is another’s revenue”



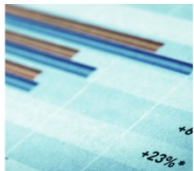
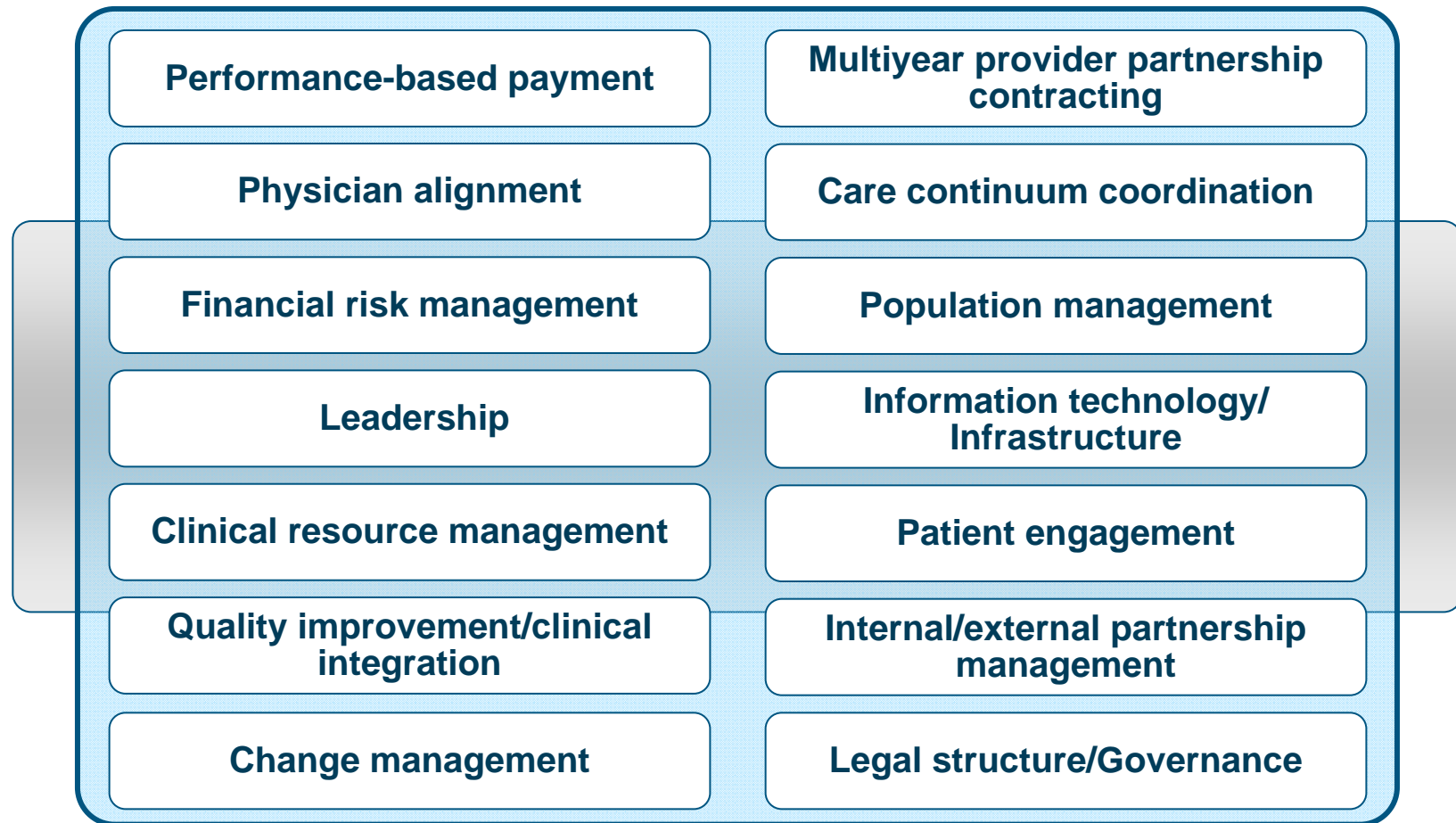
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Accountable Care Competency Stages

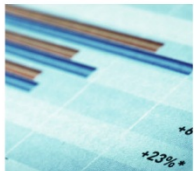
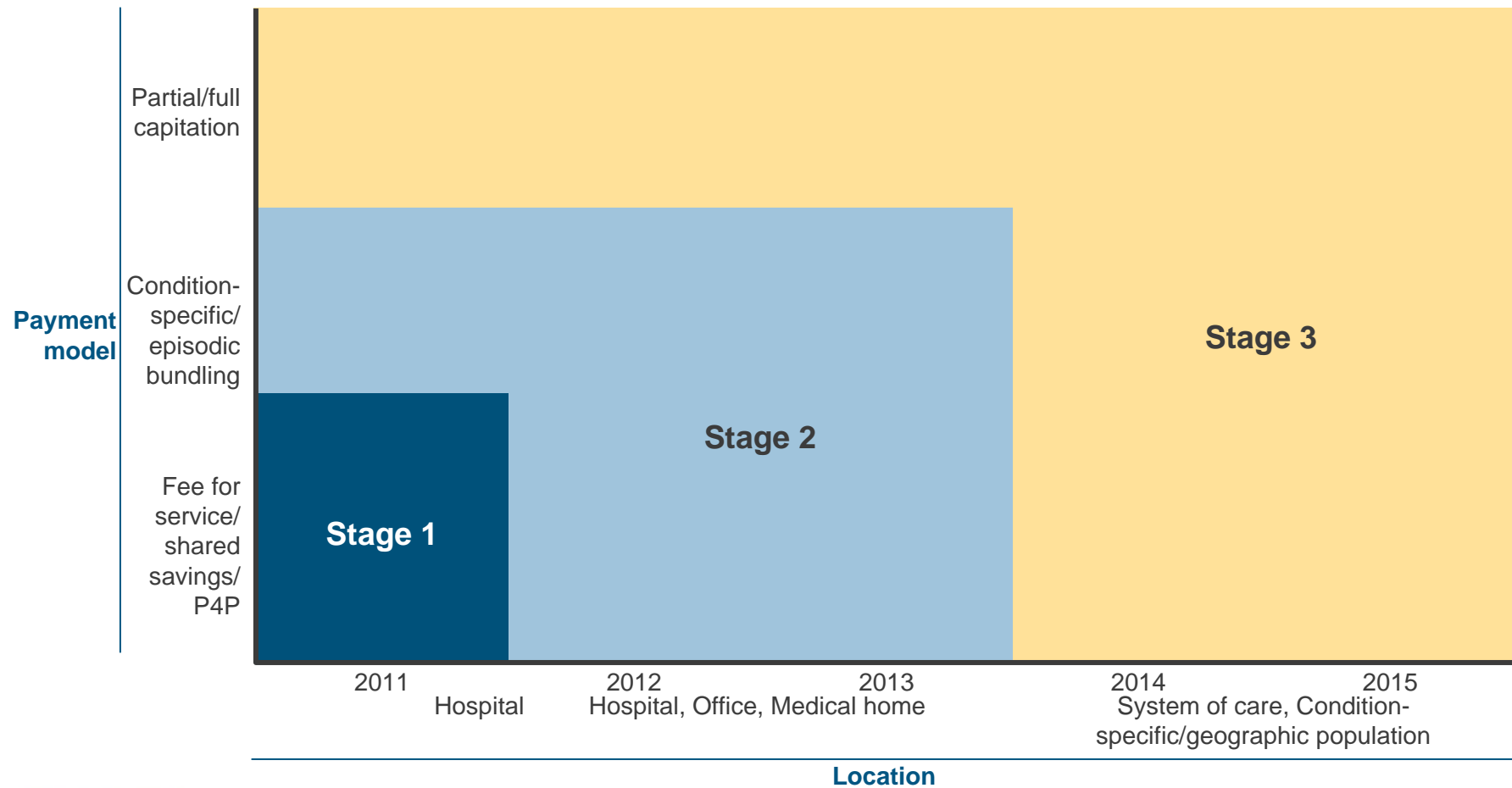


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Accountable Care Developmental Competencies

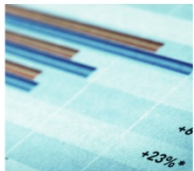
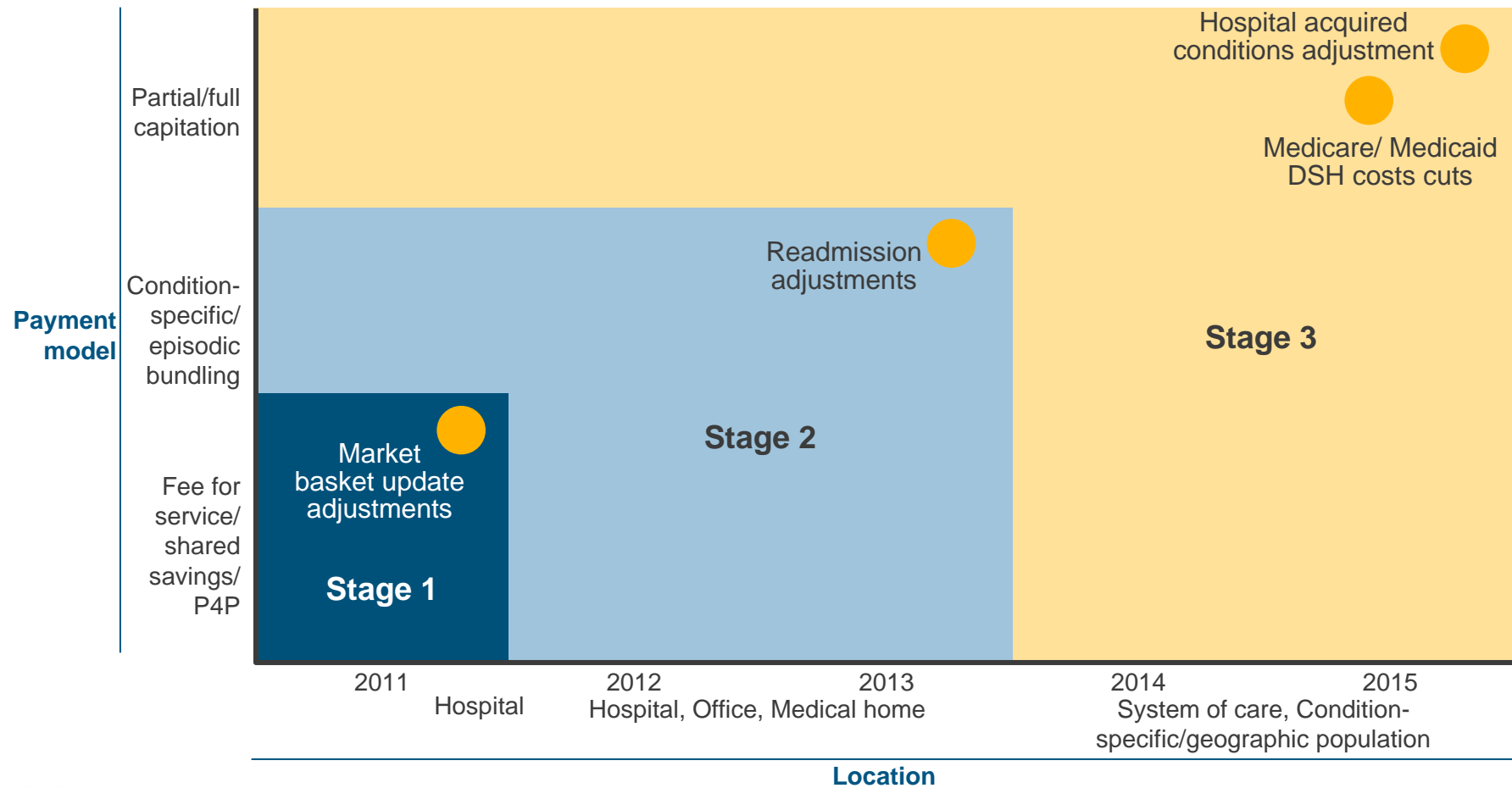


Payment Models and Developmental Capabilities



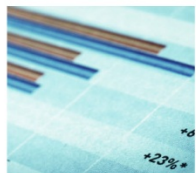
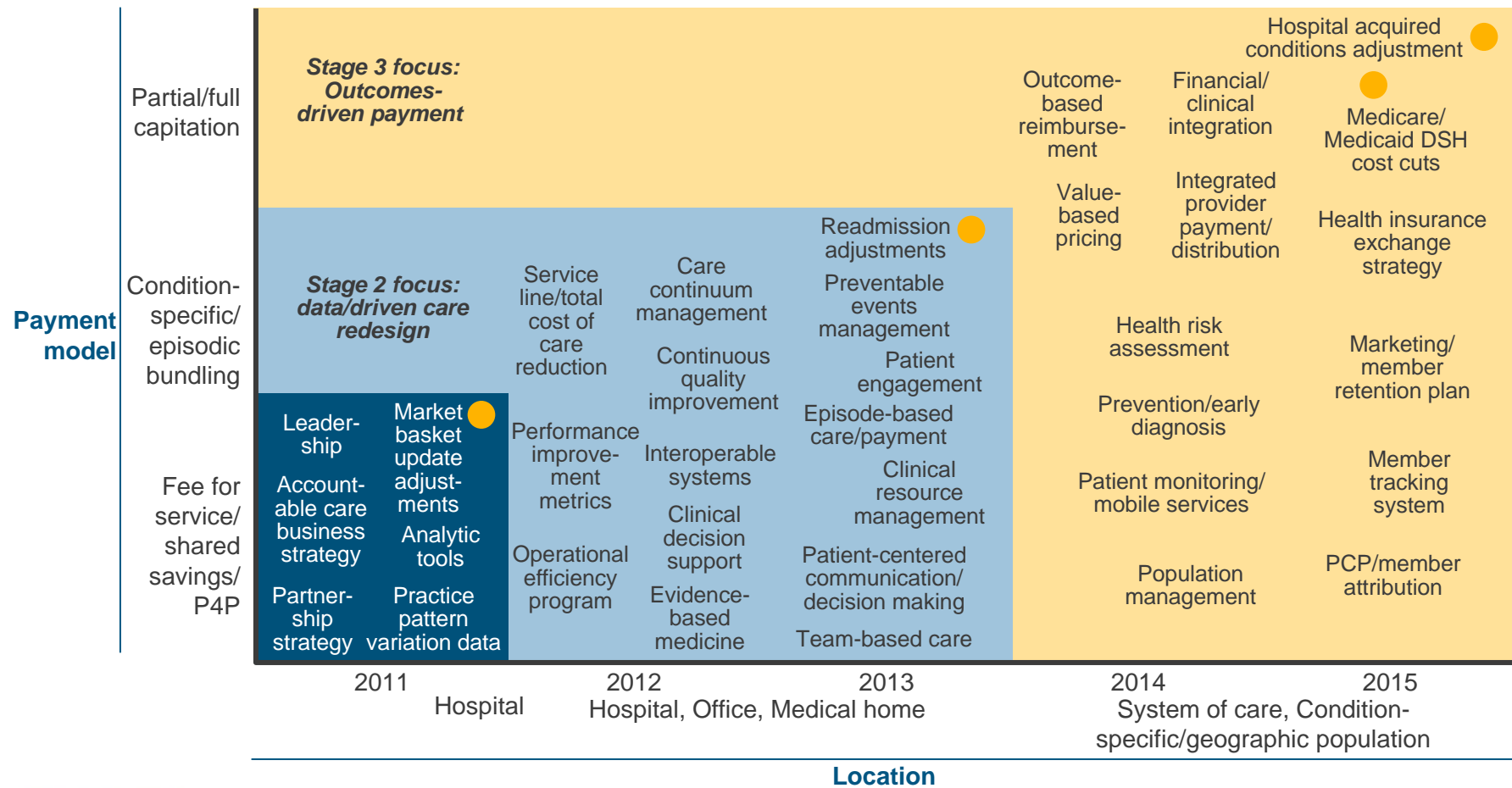
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Payment Models and Developmental Capabilities



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Payment Models and Developmental Capabilities



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Practical Cost-Reduction Measures

Medical groups

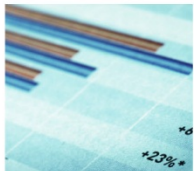
- Narrow practice pattern variation
- Monitor EBM adherence
- Institute chronic care self-management
- Incorporate email, e-visits and mobile apps

Hospitals

- Reduce potentially preventable events
- Develop e-ICUs
- Institute end-to-end pre- and post-discharge planning
- Implement full EMR functions

Health plans

- Promote value-based benefit design
- Institute reference pricing
- Offer narrow networks
- Adopt focused prescription drug management

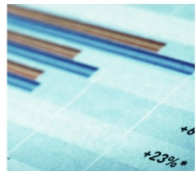


Medicare Hospital Impact

ILLUSTRATIVE EXAMPLE

Hospital	Pre-ACO			Post-ACO		
	Base rate	Volume	Total	Base rate	Volume	Total
Medicare						
Revenue	100	100	10,000	95	95	9,025
Cost	120	100	12,000	120	95	11,400
Margin	-20	–	-2,000	-25	–	-2,375
Commercial						
Revenue	160	100	16,000	150	95	14,250
Cost	120	100	12,000	120	95	11,400
Margin	40	–	4,000	30	–	2,850
Total margin			2,000			475

Source: HFS Consultants, 2011



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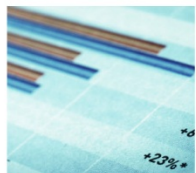
Medicare Medical Group Impact

ILLUSTRATIVE EXAMPLE

Medical group

Medical group	Pre-ACO			Post-ACO		
	Base rate	Volume	Total	Base rate	Volume	Total
Medicare						
Revenue	50	50	2,500	50	50	2,500
Cost	50	50	2,500	50	50	2,500
Margin	-	-	-	-	-	-
Commercial						
Revenue	80	50	4,000	80	50	4,000
Cost	50	50	2,500	50	50	2,500
Margin	30	-	1,500	30	-	1,500
Total margin			1,500			1,500
Combined entities margins			3,500			1,975
Add 80% of Medicare savings						780
Margin after savings add back						2,755
Distribution						

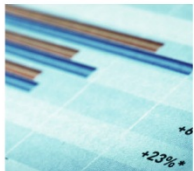
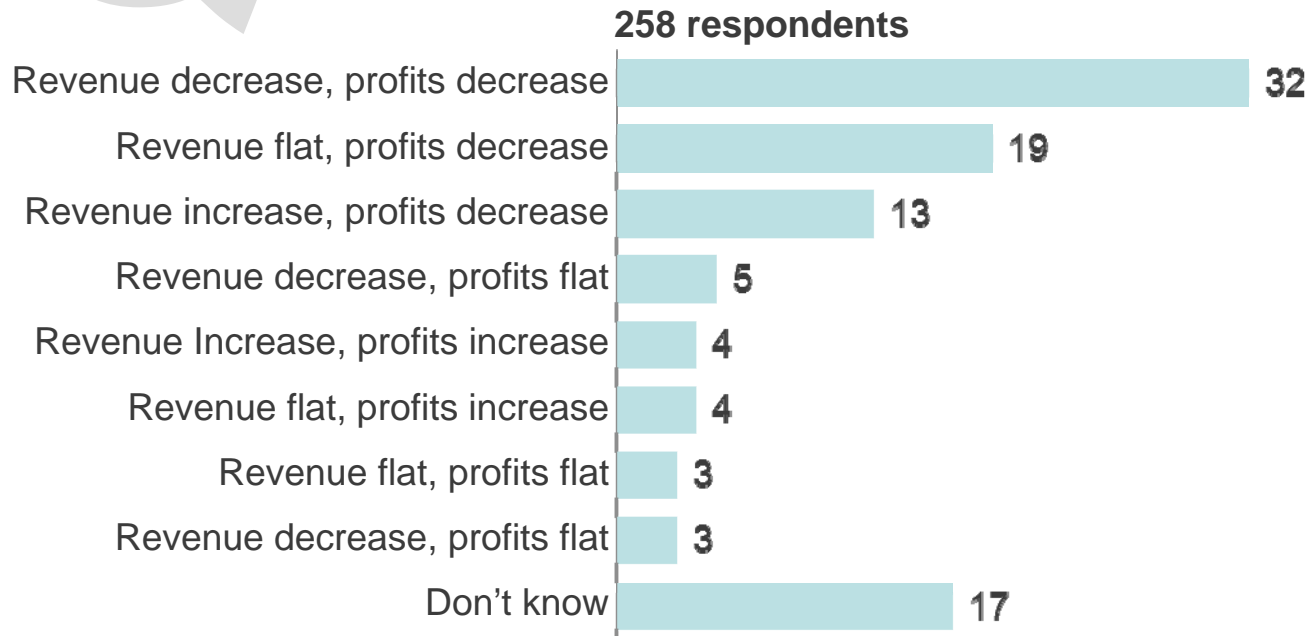
Source: HFS Consultants, 2011



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Hospital Perceptions of ACOs

Q Which phrase best describes the financial impact to hospitals you expect from medical home and ACO strategies in the future?



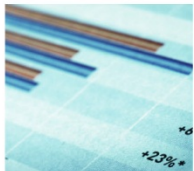
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Potentially Preventable Events and Savings



Expenditure category	Service	Potential savings
Inpatient	Readmissions	2-5%
Inpatient	Complications	1-2%
Inpatient	Initial admissions	4-8%
Inpatient	ER visits	1-2%
Outpatient	Ancillaries/procedures	2-3%

Source: Based on 3M Health Information Systems, 2011

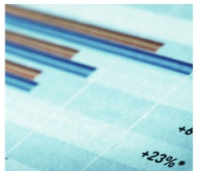


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Medicare Hospital Cost Reduction and Productivity

Hospital costs category	Operating costs percent	Potential savings percent	Productivity levers
Labor	55-65%	1-2%	<ul style="list-style-type: none">• Staffing to demand• On-call and OT efficiency• Skill mix optimization• Span of control• Process redesign
Non-labor	35-45%	2-3%	<ul style="list-style-type: none">• Strategic sourcing including aggregating demand, right specifications, expanded vendor universe, component pricing• Inventory management• Pay for performance

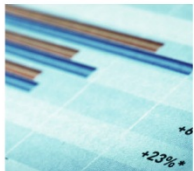
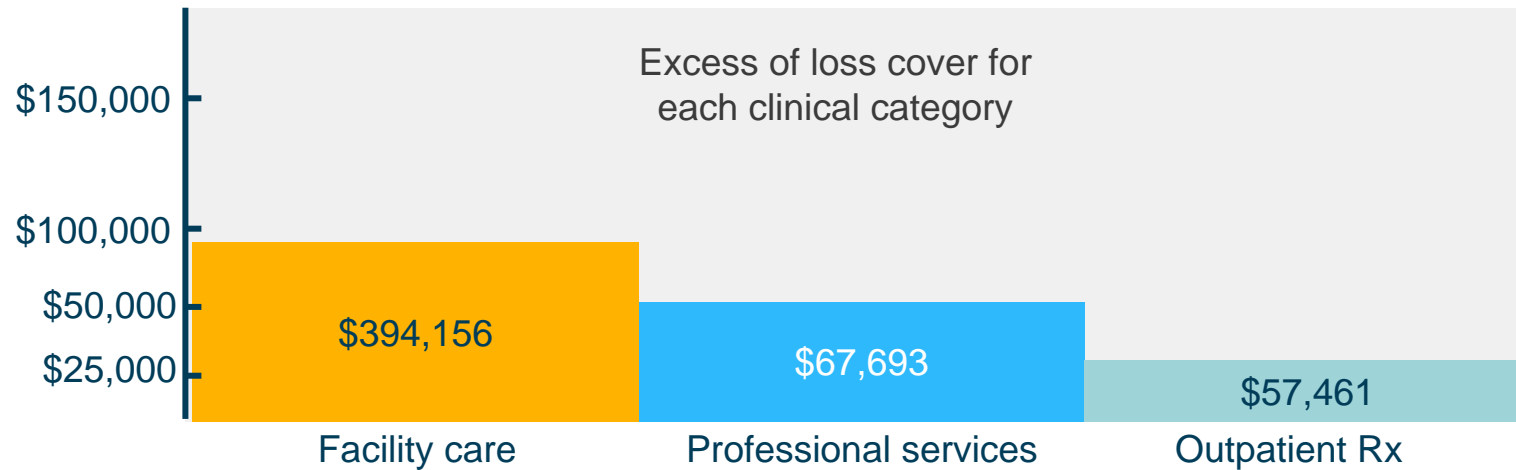
Source: HFS Consultants, 2011



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Effects of Reinsurance

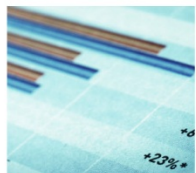
Condition	Transplant with complications – 66-year-old male		
Charges	\$1.415 million		
Payments	\$694,310 (Medicare)		
Expense class	Facility	Professional	Outpatient Rx
	\$494,156	\$117,693	\$82,461



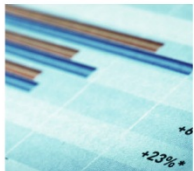
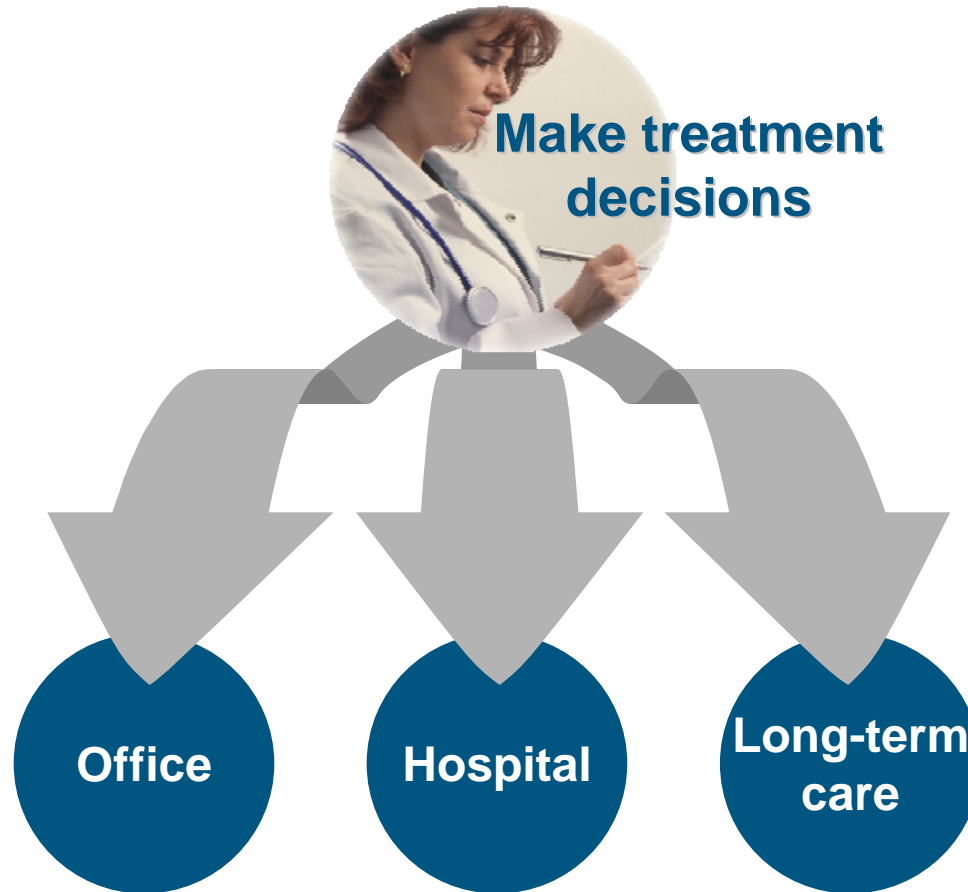
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Return on Reinsurance Investment

Total payments	\$694,310
Less deductible (combined)	\$175,000
Insurance covered expense	\$519,310
10% of coinsurance	\$51,931
Amount to be reimbursed	\$467,379
Percent of payment	67%
Estimated cost of reinsurance	2-3% of PMPM payment

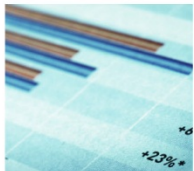
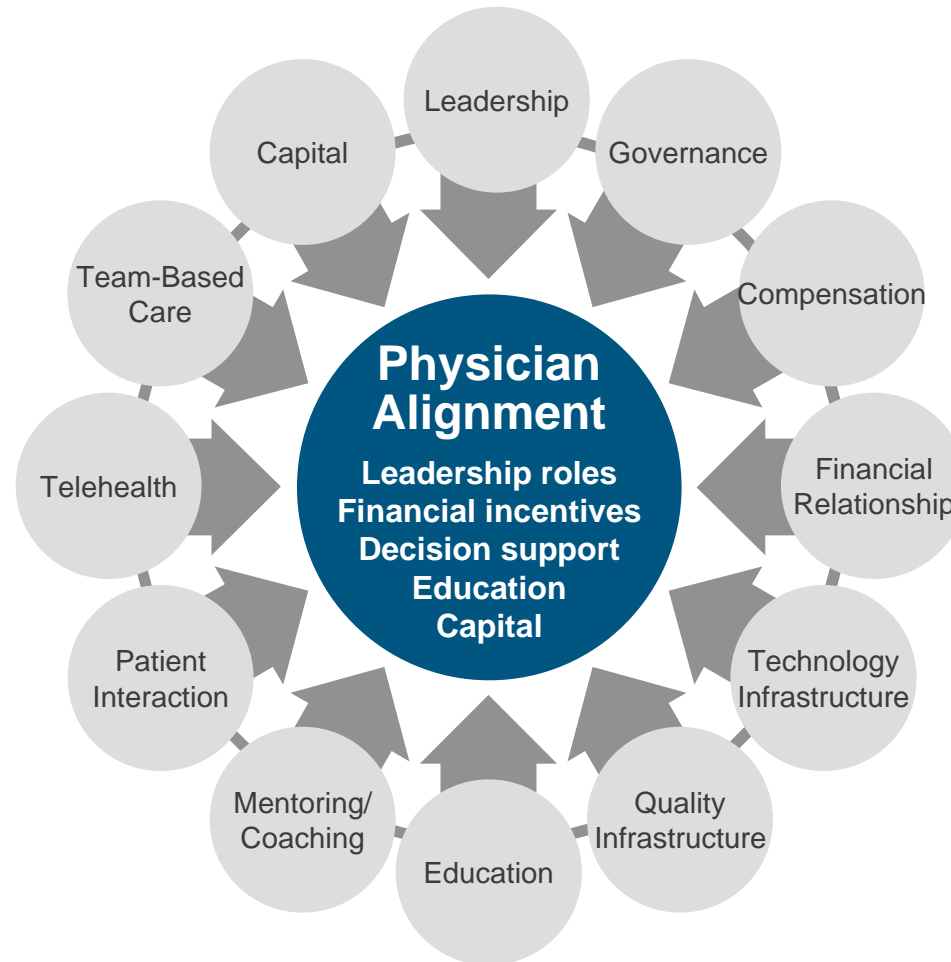


Physicians: “The Power of the Pen”



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Physician Alignment Contributors



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Physician Alignment Elements

Governance

Strategy
Policies/Procedures
Operational oversight
Compensation committee

Leadership

Board membership
Directorships
Service line co-management

Financial Relationship

Management contracts
Joint ventures
Employment

Quality Infrastructure

Evidence-based protocols
Operational benchmarks
Best practices
Patient experience feedback

Team-based care

Care coordination
Clinical integration

Compensation

Directorships
On-call
Cognitive time
Care coordination
Disease management delegation
Performance-linked
Risk corridors
Email and eVisits
Group visits/Classes
Patient communication (digital, mobile)
Web patient education

Technology Infrastructure

Clinical decision support
Interoperable data systems
Performance improvement tools
Predictive modeling
Health status indicators

Capital

Information technology
Equipment and office system upgrade

Education

EMR functionality
Evidence-based medicine
Data analysis/Interpretation
Quality indicators
Health reform reimbursement models
Team-based training
Cultural competency

Mentoring/Coaching

Outside experts
Best practices
Practice variation
Performance improvement

Patient Interaction

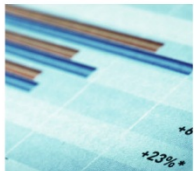
Email/Monitoring
Education/Information
Care plan adherence
Self management

Telehealth

Remote monitoring
Mobile applications

Rx

- Change management skills
- Organization cultural transformation

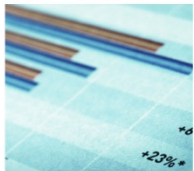


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What Do Physicians Care Most About?



- 1 Income
- 2 Practice stability
- 3 Physician-patient relationship
- 4 Office administration
- 5 Professional autonomy
- 6 Work-life balance
- 7 Quality patient care



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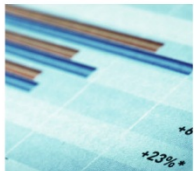
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