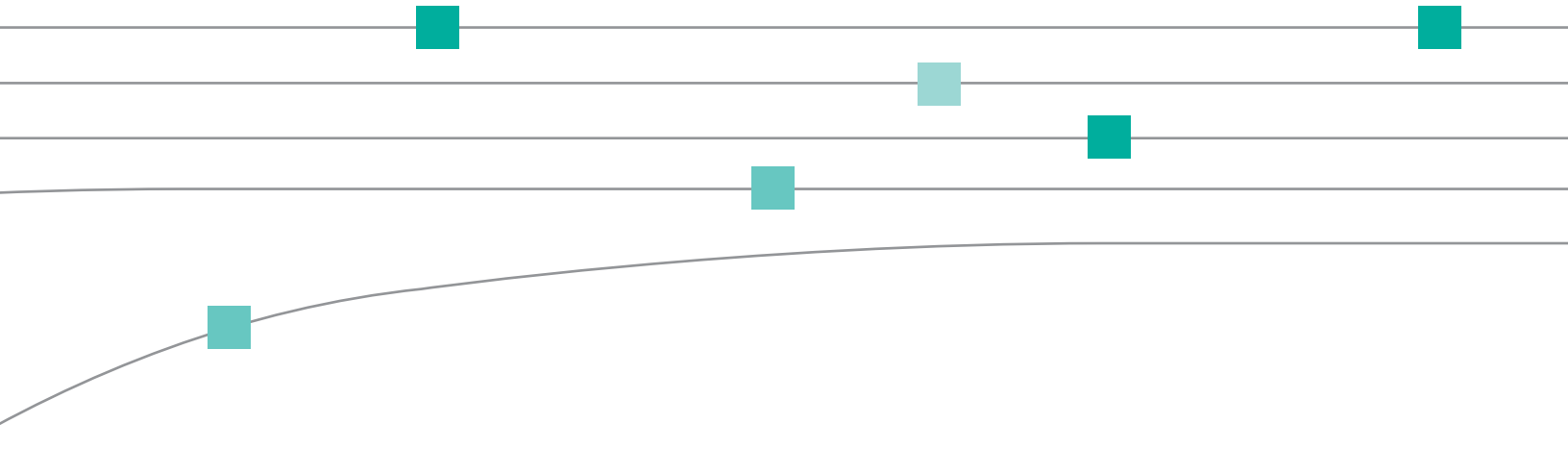
Sg2 Special Report

Accountable Care Organizations



health care intelligence

The Big Picture

In the first months since the passage of health care reform legislation in March 2010, no topic has garnered more collective consideration and hand wringing than the accountable care organization (ACO). Based on many years of work at the Dartmouth Atlas on the failings of a volume-driven health care delivery system and a relatively recent report from the Medicare Payment Advisory Commission (MedPAC), the ACO concept has become a full-fledged movement to foster local accountability for health care quality, cost and access.

Will ACOs succeed? It's too soon to tell. In the end, that may not even be the relevant question. Success during the reform decade will stem not from a particular structural solution or payment model but rather from the manner in which you organize health care in your community to meet the needs of specific types of patients. Sg2's message to health care providers is to develop the organizational competencies that optimize Clinical Alignment and Resource Effectiveness (CARE) to build high-performing Systems of CARE. In the next 3 years, it is imperative to assemble the building blocks that will improve health care value for all stakeholders, no matter how payment and insurance evolve.*

Expect the term ACO to morph into a wide range of shared savings models between hospitals, physicians, payers and employers. Some models will succeed—some will not. Many commercial payers will move faster than Medicare.

Evaluate partnership options with employers, payers, physician groups and hospitals that make sense for the communities you serve.

Anticipate encountering many economic, operational, clinical and cultural challenges in your journey toward a set of solutions that work in your market.

Start now to do the hard work to prepare for a decade of increased accountability.

A high-performing System of CARE establishes the elements necessary to succeed in an ACO marketplace. Despite many complexities, challenges and lingering uncertainties, the competencies underpinning ACOs are worthy of serious attention and steady work that must begin today.

*For more detailed analysis of health care reform and its impact on care providers, please refer to the *Sg2 Special Report: The Impact of Health Reform.*

What Is an ACO?

Broadly speaking, an ACO may be defined as a set of providers associated with a defined population of patients, accountable for the cost and quality of care delivered to that population.

The Medicare SSP: 2012–2014

- The Patient Protection and Affordable Care Act (PPACA) of March 2010 authorized a Medicare Shared Savings Program available to accountable care organizations that meet a defined list of organizational criteria.
- Participating organizations have the opportunity to share savings with Medicare for an assigned population relative to a set of quality metrics and a total cost of care benchmark.
- The pilot begins in January of 2012.

The Commercial Play: 2010+

- Providers, physician organizations, payers and employers have begun to create a wide array of shared savings programs that move beyond existing pay-for-performance initiatives.
- Models will vary in their size, structure, duration, economic approach and performance imperatives.
  - Some will resemble full capitation models; others may target specific disease categories or plan types.

Some organizations will participate in the 3-year Medicare Shared Savings Program (SSP) beginning in 2012. In addition to adopting some fundamental care delivery changes, these organizations should anticipate many challenges and frustrations with regulatory complexity, CMS patient assignment methodologies and retrospective Medicare claims analysis.

Many organizations will enter next-generation, pay-for-performance initiatives with local physician groups, payers and employers. These models will be challenging to set up but will allow for more precise patient targeting, easier monitoring of patient populations and flexibility to change approaches over time.

All organizations must begin to prepare for payment models that require a greater level of accountability around specific cost and quality metrics.

CMS = Centers for Medicare & Medicaid Services.

What We Know—And What We Don't

What is an ACO?

Beyond a handful of pages in reform legislation around "shared savings," "coordination of services," "investment in infrastructure" and "redesigned care processes," no clear definition yet exists. Over time, an ACO will comprise a wide array of approaches for assuming clinical risk, improving quality and reducing the rate of expenditure growth for defined populations of patients. Medicare's definition of an ACO will be clarified in late 2010 and may differ from commercial payment approaches.

What will ACOs try to do?

ACOs will try to improve quality and reduce the cost of care through different approaches to disease management, risk management, telephonic patient management, home monitoring, transitional case management, palliative and end-of-life care, quality improvement initiatives and care standardization. Specific targets for cost reduction will be avoidable admissions, readmissions, overuse of diagnostic tests and emergency department visits, as well as high rates of certain elective surgical procedures.

Who can form an ACO?

While provider systems have expressed the most interest thus far, ACOs will eventually include different combinations of health plans, physician groups, hospital systems, physician-hospital organizations (PHOs) and independent practice associations (IPAs).

Is this 1994 all over again?

Yes and no. Information technology (IT) has evolved, quality metrics have matured and physicians are more interested in participating, but the goal of reducing utilization of high-cost services remains the same. This time the models will focus more on the patient and quality and are more likely to succeed.

Do ACOs already exist?

Not exactly. Kaiser Permanente and health systems that own insurance plans possess the infrastructure and many of the competencies that will eventually define ACOs, but the best examples of ACOs are the physician groups that have participated in the Medicare Physician Group Practice Demonstration pilot. Their experiences in trying to achieve savings targets for Medicare provide the best guidance for any organization interested in navigating the ACO landscape.

Who is best prepared to become an ACO today?

Those organizations with direct experience in commercial capitation plans, large multispecialty physician organizations, Medicaid and Medicare managed care programs and/or those providers operating under Federal Trade Commission (FTC)–approved clinical integration models will have a relatively easier time moving to an ACO model.

Should my organization become an ACO?

You don't have to, and an ACO structure may not make sense for your organization or market. Over time, however, all physicians and hospitals will work under a variety of pay-for-performance programs that reward care coordination, clinically indicated utilization of health care services and exceptional quality. Your market share will depend upon your ability to manage high-performance Systems of CARE.

How will patients benefit from ACOs?

Patients with chronic conditions may benefit from improved care, better care coordination and increased access, but many ACO structures may be invisible to patients and families. Some commercial ACOs may experiment with ways of sharing savings with enrollees; others may promise reduced insurance premiums.

What We Know—And What We Don't (Cont'd)

How are ACOs different from bundled payment?

Bundled payment refers to a packaged price for hospital and physician services for a defined care episode. Medicare is piloting bundled payment for certain cardiac and orthopedic procedures through the ACE Demonstration project. Bundled pricing is one approach that ACOs may use to reduce costs.

How is an ACO different from the medical home model?

The medical home refers to a variety of patient-centered, team-based care coordination models that often focus on chronic disease populations. Many ACOs will use medical home approaches to achieve cost-savings targets. The lessons learned from medical home pilots in patient tracking, performance measurement, reporting and communication will be invaluable to organizations developing ACOs.

As an ACO, will it be necessary for us to have our own health plan?

No. ACOs are more about *clinical* risk (ie, reducing utilization and improving quality) than *insurance* risk. Payers will have important roles to play in ACOs in managing claim streams, actuarial issues, enrollment and risk adjustment.

How much is this going to cost us?

The answer will vary dramatically by organization. On average, participants in the Medicare Physician Group Practice Demonstration spent about $500K to initiate the pilot and over $1M on annual internal initiatives to administer the program and deploy new care delivery models to support program goals. Far higher than these costs may be the cost of time invested across an organization and the opportunity cost of not focusing on other priorities.

What will the minimum scale be?

An ACO must be of sufficient size to ensure actuarial stability. MedPAC suggests no fewer than 50 physicians and 5,000 patients, but most pilots will be many times larger. Tying financial incentives to cost and quality metrics will require a large enough patient base to minimize the unavoidable static in the data. Larger ACOs will have more stable patient risk pools and the capital to support the infrastructure, analytics and reporting requirements to manage to the targets.

Will the electronic medical record (EMR) system be enough?

Unfortunately, no. The inpatient and outpatient EMR is just the beginning. A level of analytic capability and real-time responsiveness above current clinical documentation will be required. Tools to help with predictive modeling and risk stratification also will be important. Efficiently and legally sharing information across organizations and care sites will be essential for care coordination, quality improvement and cost reduction.

How do we do this without violating legal concerns?

Moving in this direction, especially with independent physicians, is rife with legal regulations, including Stark law, fraud and abuse concerns, antitrust issues and potential challenges to tax-exempt status. CMS, OIG, IRS and a host of others still need to weigh in on the legal hurdles. In the meantime, involve your legal team in even the early conversations to minimize these risks.

What if the whole thing doesn't work?

Good question. Cultivating the qualities of a strong accountable care organization will be needed anyway, whether you pilot an ACO in the near-term or gear up for the Medicare Shared Savings Program. The principles underpinning ACOs are worthy of early attention and action.

ACE = Acute Care Episode; OIG = Office of Inspector General; IRS = Internal Revenue Service.

Timeline of Reform

A Decade of Medicare Reform and Shared Savings Programs

What the Law Says

Fall 2010:
CMS to release formal guidelines on Medicare Shared Savings Program

2012:
Initiation of Medicare Shared Savings Program (January 1)

Additional ACO-Related Provisions

2010–2011:

- Extension of gainsharing demonstration project (2010)
- Medicaid global payment demonstration project (2010)
- Medicare pay-for-reporting via electronic registries (2010)
- Center for Medicare and Medicaid Innovation begins testing new payment and delivery models (2011)
- Plans submitted for VBP program for skilled nursing, home health, ASCs (2011)
- Center for Medicare and Medicaid Innovation reinforcing payment reform (2011)

2012–2013:

- Medicare VBP program (2012)
- Initiation of pediatric ACO demonstration program (2012)
- Payment reductions based on discharges for hospitals with an "excess readmissions ratio" (2012)
- Bundled payment demonstration program for Medicaid patients (2012)
- Medicare bundled payment program (2013)

2010–2013:

Implications

The Prelude

- Providers move aggressively to lock in a primary care base and compete aggressively for market share in a slowing market.
- A range of ACO models emerge—hospitals, physician groups and payers take immediate steps to secure the strategies, partners and infrastructure for ACO development in order to meet 2012 Medicare Shared Savings Program deadlines and similar programs for the private sector.
- Medicare ACO program regulations undergo several rounds of refinement through the pilot period.
- States begin experimenting more aggressively with ACOs in their Medicaid programs.
- Additional incentives emerge for providers to coordinate with post-acute care providers.
- New care delivery models, like the patient-centered medical home, gain momentum among commercial payers.
- Commercial payers begin to negotiate provider contracts more aggressively and relaunch narrow network options. Network provider models reemerge in some markets.
- Employers become more aggressive in transitioning to high-deductible plans with great cost-sharing requirements.

VBP = value-based purchasing; ASC = ambulatory surgery center; HAC = hospital-acquired condition.
Sources: PPACA, 2010; Hastings D. The timeline for accountable care: the rollout of the payment and delivery reform provisions in the Patient Protection and Affordable Care Act and the implications for accountable care organizations. *BNA Health Law Reporter* March 2010; Kaiser Family Foundation. *Health Reform Implementation Timeline*. 2010; Sg2 Analysis, 2010.

2014–2017:

- Efficiency measures added to Medicare VBP program (2014)
- Quality reporting mandates for long-term care hospitals, rehab and hospice programs; rate reductions for noncompliance (2014)
- 1% payment reductions for hospitals in the highest HAC discharge quartile (2015)
- Medicare fee reductions for physicians who do not meet data submission requirements for quality measures (2015: 1.5%, then 2%)

2018–2020:

- Medicare bundled payment program potentially extended (2018)
- MedPAC independently implements more aggressive payment reform models
- Next-generation payment pilots launched

2014–2017:

Market Expansion

- Rapid coverage expansion occurs: first steps are taken toward 32M additional Americans receiving coverage.
- State insurance exchanges include provider-specific benefit plans.
- Hospital and insurance payment rates flatten and become a matter of public record.
- Many markets achieve successful reduction in disease-specific utilization rates.
- Medicare ACO programs and commercial models evolve into a portfolio of shared savings initiatives.
- Medicare physician payment reform phases in over multiple years and accelerates provider consolidation.

2018–2020:

Regulation and Restructuring

- Capacity constraints intensify in certain specialty areas in some markets, highlighting an increasingly tiered health care system.
- ACOs begin to span larger regions.
- ACO success metrics evolve from process based to outcome based.
- Hospitals become cost centers for ACOs.
- New proposed Medicare regulations create uncertainty for the next decade of health reform.

Positioning for ACO Development—What's in It for Each Player?

Development of high-performing Systems of CARE or formal ACOs requires a deep, local understanding of the current capabilities, perspectives, biases and incentives of each potential participant. Overcoming structural barriers, cultural resistance and infrastructure limitations will take a combination of time, a willingness to experiment, carefully calibrated incentive models and a clear strategic upside for each player.

Employers

Large employers may see an opportunity to reduce overall employee benefit costs, particularly if their employee population includes a high percentage of individuals with chronic illnesses or with unusually high utilization rates for certain elective procedures. At the same time, employers may be reluctant to participate in any untested program that requires them to release claims data or could raise concerns about employee health care confidentiality.

Payers

Established payers are already taking steps to prepare for the post-2014 marketplace. They may see an opportunity to increase market share by developing lower-cost, higher-service insurance products for small groups and individuals. They may question providers' willingness to work under a different rate structure or to share in the downside if promised savings do not materialize.

Physicians

Independent and aligned physicians may be suspicious of any program designed to reduce the cost of health care for payers and hospitals. In order to participate they must receive a fair share of the cost savings and/or receive individual monthly stipends for additional time spent coordinating care for specific patients who visit their practices. In many markets, the physician may be the stakeholder who least understands the need or reason to undertake ACO initiatives. Extensive ongoing education and data sharing will be required to encourage physicians to participate.

Community Health Systems

Health systems may see the ACO as a vehicle to cement or increase market share, a means to prepare for the economics of the decade ahead or an intelligent way to address the health care needs of the populations they serve. Many organizations may not see the upside of changing their delivery models before volume-based incentives begin to sunset.

Academic Medical Centers

Academic medical centers (AMCs) will participate in ACOs in a variety of ways. In some markets AMCs may become the anchors and coordinators of larger regional ACOs or healthcare innovation zones (HIZs). In other markets AMCs may partner with one or more community health systems or physician organizations to support secondary and tertiary services across the System of CARE. AMCs must also find different ways to participate in a market that will emphasize low-cost primary and secondary care.

Patients

In order for patients to be willing to participate in this movement, ACOs must either be invisible to them or promise a product that is superior in a combination of cost, quality and access on their terms.

ACO Development: A Spectrum of Options

The success of ACOs will be defined more by System of CARE competencies than by a specific structure. Fully integrated health systems and large multispecialty physician groups may have advantages in their ability to initiate and manage pilots, but each ACO model will have its share of benefits and unique challenges.

Spectrum of ACO Models

	Virtual Model	Partially Integrated Model	Fully Integrated Model
Description	■ Patients assigned to ACO based on geographic proximity ■ Providers may or may not have any formal structural ties ■ Savings measured retrospectively from geographic population claims analysis ■ One proposed approach to long-term Medicare payment reform	■ Moderate risk-sharing arrangement ■ Collaboration between ACO partners through joint ventures, comanagement agreements, PHOs, IPAs, clinical integration programs	■ Full risk-sharing collaboration of providers and payers ■ Strong legal ties between parties ■ Patient-centered medical home model ■ Patients enrolled into the ACO
Benefits	■ Requires little formal planning ■ May be an effective option for markets without large physician organizations	■ Creates a degree of financial and clinical integration to move providers toward greater integration over time	■ Size and scale can be leveraged to invest in needed infrastructure ■ Greater control over care delivery to control costs and improve quality ■ Greater protection from laws and regulations governing hospital-physician relationships
Challenges	■ Design of shared savings model ■ Limitations and constraints on managing utilization and quality	■ Capital to develop infrastructure ■ Leadership and governance structure required to support cultural transition	■ At full risk for the upside and downside of ACO performance
Examples	■ N/A: Awaiting Medicare Demonstration pilot	■ Tucson Medical Center ■ Memorial Hermann Healthcare System ■ Washington Co/TriState Health Partners ■ Advocate Physician Partners	■ Kaiser Permanente ■ Geisinger Health System ■ Next-generation clinical integration models

ACO Development: Shared Savings Program

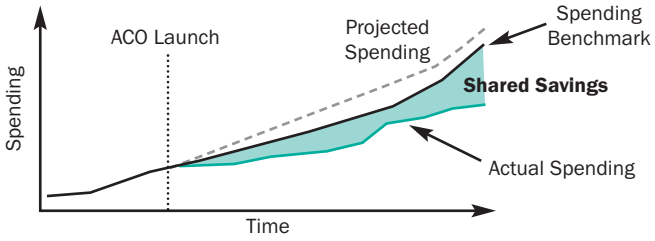
Perhaps the greatest challenge in navigating the ACO environment will be working under the Medicare Shared Savings Program or designing a local shared savings model for commercial pilots.

How the Shared Savings Program Works

- ACO establishes a spending benchmark.
- If quality targets are met within that spending target, shared savings from the payers are then distributed to participating providers.
- Incentives are designed to support stronger coordination with outpatient wellness services in order to improve outcomes while meeting spending targets.

How Do "Shared Savings" Models Work?

Initial shared savings derived from spending below benchmarks



Key Questions to Consider

- How frequently will the shared savings be distributed?
- What will the distribution percentage be to the parties involved?
- Will shared savings targets shift annually?
- As the shared savings program evolves, what will be the reasonable level of risk assumed on the downside?

Designing the Shared Savings Plan Locally

Each organization may deploy a slightly different shared savings approach based on its structure, physician alignment models, accounting systems and cultural tolerance for risk.

Potential Starting Places

Consider options to engage physicians effectively at the outset, financially incentivize them for pioneering this with you, and cover some of their costs (eg, case managers hired for a medical home).

- Incentive payments to physicians for meeting quality targets
- Health plan willing to provide seed money to primary care practices for medical home models
  - Example: Per-member-per month program to give the physician practices additional money up front for engagement around improvements in disease management (eg, congestive heart failure, diabetes)

Payment Models Will Advance Toward Greater Risk and Reward

Simple Shared Savings

- ACO to continue to be paid on a fee-for-service basis
- Provides an easy, low-risk starting place for providers with little or no up-front resources required, though limited rewards

Symmetrical

- At risk for spending exceeding projections
- Offers the greatest rewards but also creates strong incentives for savings

Partial Capitation

- Up-front payments, plus a share of the savings
- Prospective payments offer up-front resources, but greater risk involved will require stronger financial oversight

Sources: Brookings-Dartmouth ACO Learning Network Webinar, September 3, 2009; Fisher E. Why accountable care? Core principles underlying ACOs. The Dartmouth Institute for Health Policy and Clinical Practice: June 2010.

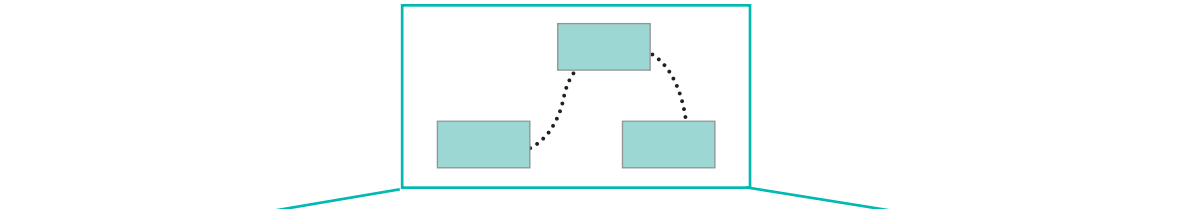
ACO Development: Performance and Growth Analyses

Avoiding the same pitfalls of the 1990s will require ACO partners to maintain the right focus: performance improvement across the continuum of care and smart growth.

Performance and Growth Analyses

Preparing to become an ACO can begin with asking, "How well are our disease-specific Systems of CARE doing currently?" This requires analyses beyond the inpatient setting to measure and improve performance in the community-based and rehab/recovery care segments as well. Concise yet progressive metrics will be essential.

Use Metrics to Gauge Performance Across the System of CARE



Avoidable Admissions

- Potentially avoidable admissions
- Avoidable visits

Length of Stay

- Length of stay and associated cost per case

Readmission

- 30-day readmissions
- Multiple readmissions

Key Considerations

- Begin by establishing common disease-specific quality metrics across all sites and providers of care.
- Develop the capability to compare quality by site of care and by physician.
- Build momentum with sustainable change at the disease level, then implement larger-scale efforts toward the formation of an ACO.

Performance and Growth Indices

The **Sg2 Value Index™** is a scoring system designed to help hospitals set performance improvement goals that will bring about measurable change. Scores are derived using key metrics that span the care continuum, including potentially avoidable admissions, LOS, cost per case and 30-day readmissions. Monthly updates and 24-month trending analysis track the effectiveness of performance initiatives and provide comparisons against leading practices and peer hospitals in the Sg2 database.

The **Sg2 Growth Index™** profiles your existing patient mix and illustrates how it influences your organization's ability to achieve profitable and sustainable growth. It examines your organization's rate of potentially avoidable admissions and 30-day readmissions to determine whether you have the necessary primary care infrastructure and care coordination processes to capture appropriate growth and lessen financial risk. As such, the Sg2 Growth Index serves as an impetus for discussing opportunities for investment, partnering and building to create your optimal System of CARE.

For more information, see pages 17–18 and visit www.sg2.com.

ACO Development: Readiness Assessment

A careful and balanced assessment of ACO readiness will highlight existing strengths and potential gaps impacting early development plans.

Vision, Leadership and Culture

- ☐ Clear vision of what you are trying to achieve through the Prelude period of reform
- ☐ Deep leadership team with strong physician and nursing executives
- ☐ Cultural readiness and incentive structure to work under different accountability and incentive models

Cost and Quality Performance

- ☐ Wage index– and case mix–adjusted cost per case
- ☐ Length of stay
- ☐ Utilization rates for specific elective procedures
- ☐ Current operating margins relative to Medicare rates
- ☐ 30-day readmission rate
- ☐ PQI rate (potentially avoidable admissions)
- ☐ Patient satisfaction and loyalty
- ☐ Sg2 Value Index*
- ☐ Physician-level quality and cost data
- ☐ Disease-specific quality metrics

Existing Strengths

- ☐ Cohesive, closely aligned primary care base
- ☐ Experience with Medicare Advantage
- ☐ History of working under capitation
- ☐ Existing durable physician organizational structures: PHOs, PSAs, IPAs, MSOs
- ☐ Own a health plan
- ☐ Can identify a willing payer for collaboration efforts
- ☐ Pilot in progress for medical home
- ☐ Pilot in progress for bundled payment
- ☐ Large employed medical group
- ☐ Potential partners: large multispecialty group, AMC, community hospital in adjacent market
- ☐ Participation in ACO collaboratives: Brookings-Dartmouth, Premier, AMGA or regional
- ☐ FTC-approved clinical integration program

Market Strength

- ☐ Disease-specific operating scope and scale
- ☐ Market share in primary and secondary service area
- ☐ Physician loyalty relative to competition
- ☐ Smart Growth position (inpatient and outpatient; Sg2 Growth Index* defines smart growth as appropriate, profitable and sustainable)
- ☐ Market share reach and penetration
- ☐ Strong balance sheet and cash flow position
- ☐ Strategic partnerships across the continuum

Essential System of CARE Competencies†

- ☐ IT system deployed across the care continuum
- ☐ Ability to use data and analytics to measure and monitor performance
- ☐ Experience in creating strategic partnerships across the continuum
- ☐ Success in reducing unnecessary admissions by targeting high-risk patient populations
- ☐ Capability to track patient care and ensure follow-up
- ☐ Robust resources for patient education and self-management
- ☐ Leadership skills to plan, organize and deliver clinically integrated care
- ☐ Adept at accelerating implementation timelines for performance initiatives

*See appendix, page 17, for more information on Sg2 analytics. †See page 16 for more details.
PQI = Prevention Quality Indicator; PSA = professional services agreement; MSO = management services organization; AMGA = American Medical Group Association.
Sources: Miller HD. *Pathways for Physician Success Under Healthcare Payment and Delivery Reforms*. AMA and Center for Healthcare Quality and Payment Reform: June 2010; Sg2 Analysis, 2010.

ACO Development: Private Sector Examples

Leading Practice: CalPERS Pilot, Northern California

Background

- CalPERS Pilot includes several elements and building blocks of an ACO, although the program is not explicitly referred to as an ACO.
- Partners include Catholic Healthcare West (CHW) hospitals, Hill Physicians IPA and Blue Shield CA.
- Initial discussions began in 2008 with an official launch in January 2010.
- 41,000 CalPERS members are included in the pilot.
- A separate entity was not formed; the model is a "virtual corporation" between the 3 parties.
- Current focus is on the commercial HMO product.

Structure

- Objective: to reduce the cost of health care and improve quality and service for CalPERS members at lower premiums. CalPERS members are financially motivated to select NetValue Providers. In CY 2010, Blue Shield NetValue had lower employee out-of-pocket contributions compared to the previous year.
- Blue Shield provides some level of risk adjustment.
- Early areas of focus are utilization and cost reduction opportunities in hips, knees, spine, gynecologic surgery and bariatric surgery.
- A 3-way risk-sharing agreement across 6 service categories, tracked monthly, allows parties to share in the upside and downside of financial performance within the quality parameters.

Challenges

- Cultural obstacles in coordinating the payer, hospital and physician perspectives
- Engaging members directly to provide information and incentivize desired behavior changes
- Designing an effective population management system
- Creating efficient, regulatory compliant and effective information sharing across the 3 parties to support real-time access to the inpatient clinical record and patient management across the continuum

Critical Success Factors

- 40,000 members: sufficient size to create meaningful data
- A well-managed IPA
- Strong utilization management strategies:
  - — Shared information through the EMR system
  - — "Teach back" program: patients are asked to repeat back to the nurse prior to discharge why the follow-up visit with their primary care physician is necessary
  - — Daily rounds to directly engage caregivers in reviewing the patient's clinical pathway, identifying posthospital needs and securing authorizations for discharge
  - — Prior authorization to enforce evidence-based medicine
  - — Focus on clinical pathways
  - — Preventing non-CHW admissions and readmissions
- Public validation of the pilot from CalPERS
- Early emphasis on and enforcement of collaboration by senior management to build a necessary level of trust and relinquish historical turf to allow for information sharing
- Addressing the many legal issues impacting information sharing
- Aligning financial incentives across stakeholders

CalPERS = California Public Employees' Retirement System; HMO = health maintenance organization.
Source: Sg2 Interview With CHW, July 19, 2010.

ACO Development: Private Sector Examples (Cont'd)

Leading Practice: Tucson (AZ) Medical Center (TMC)

Background

- Initial discussions in 2007 focused on structures for building stronger alignment with primary care physicians (PCPs) and specialists through 2 comanagement agreements (cardiovascular, orthopedics/neurosurgery).
- TMC operates in a highly competitive market.
- The majority of physicians on the Tucson medical staff are independent.
- TMC has 1 small employed medical group.
- Strong support for developing an ACO came from UnitedHealthcare of Arizona.

Structure

- United Healthcare started 7 patient-centered medical home pilots in Arizona: 4 are in Tucson (1 with TMC's employed physician group); the other 3 are with independent physician groups.
- In September 2009 TMC was named 1 of the 3 Brookings-Dartmouth pilots, along with Norton Healthcare in Louisville, KY, and Carilion Clinic in Roanoke, VA.
- A steering group of physicians has been formed to lead the ACO development process. Members were already participating in patient-centered medical homes and were specifically selected to be part of the ACO development.
- Approximately 50 to 60 primary care physicians will participate in the ACO.
- The shared savings plan is in the development phase, led by the physician steering group.
- On June 1, 2010, the plan went live on EPIC.
- An MSO will provide traditional management support for the ACO and the medical home models, along with billing services.
- There are plans to develop an LLC structure with TMC as a minority partner, structured similarly to the current comanagement LLCs in place.
- Next steps include: contracts with UnitedHealthcare; preparing for the Medicare Shared Savings Program; developing the infrastructure for information sharing across parties; and creating the quality metrics and reporting processes.

Challenges

- Internal concerns regarding the impact to the hospital had to be addressed. The hospital and UnitedHealthcare are trying to determine how the pilot will affect utilization that favors the hospital today.

Lessons Learned and Critical Success Factors

- Creating a collaborative model that was physician driven rather than hospital centric was critical.
- Initiating strategies 3 years before implementation helped to develop stronger physician relationships.
- Developing comanagement agreements increased trust "to support a new level of dialogue."
- Strong support from UnitedHealthcare of Arizona has been essential.

Source: Sg2 Interview With Tucson Medical Center, May 21, 2010.

ACO Development: Private Sector Examples (Cont'd)

Leading Practice: Sentara Healthcare, Norfolk, VA

Background

- Sentara has an inpatient and outpatient EMR system; 7 of the 8 hospitals are on the inpatient system, and nearly all of the employed physicians are on the ambulatory EMR.
- A 400+ employed medical group focuses mainly on primary care.
- Sentara's health plan (Optima) has 400,000 covered lives; 20,000 members are in an ACO "readiness" pilot initiative.

Structure

- Objective: Assess the infrastructure needs of an ACO by January 1, 2011.
- Focus was on managing select chronic disease patients within the Optima membership.
- The ACO pilot identified 5 employed primary care practices. Optima patients represent 20% to 25% of the practices.
- ACO efforts are part of the Sentara Healthcare Transformation of Care Strategic Imperative, led by Sentara CEO, Howard Kern.
- Development is timed to assess value of participation in the Medicare Shared Savings Program, while utilizing the pilot to facilitate accountable relationships between the Optima member and the PCP, the PCP and specialists, and the PCP and the hospital and other post-acute providers. As more information is gathered, engagement of other commercial payers concerning Sentara's capabilities and the payers' objectives will be more meaningful and actionable.
- The CEOs of the health plan and the medical group are the cosponsors of the Alignment and Accountability Initiative, which includes ACO development and bundled payment planning focused on total care payments and total cost of providing care across a continuum of services.
- PHO, clinical integration and foundation models are being discussed as potential structures for independent PCPs to manage assets and distribute savings.
- An MSO, developed using health plan capabilities but offered as a separate product of the health system, is a potential means to offer provider and insurer contracting and a payment adjudication structure for the Sentara ACO and other ACOs.
- A development team will consist of physician providers (independent and employed), facility executives and health system executive leadership, as well as Optima health plan representatives.
- Specialists are initially reimbursed for their time spent designing standardized care processes, or through reinvestment in clinical program development.
- The desired endgame is a risk-bearing organization assuming the total cost of care.

Challenges

- Financial modeling and creating the value proposition, especially for the hospital, given the significant impact expected
- Forecasting how expected changes will impact components of the delivery system and right-sizing future services, from scope of services to location, to better use of existing investments
- Forecasting expenditures, with concerns over the accuracy of forecasting total cost of care based on past expenditures
- Managing internal preconceived notions of what an ACO is and articulating the important differences between current models and those of the 1990s
- Determining how to share savings with independent physicians, especially savings from the production of care
- Planning for and engaging physicians in an endgame without awareness of all the rules and based on rules that will likely change

Lessons Learned and Critical Success Factors

- Start small and grow involvement gradually. Small pilots to gain experience, to achieve results and to expand upon are beneficial.
- Support existed from senior management from the outset.
- Engaging the physicians and payers early on in the development process was essential.
- After a challenging history with an IPA in the 1990s, successful engagement required focusing on the value of clinical integration (eg, patient care, better outcomes) to build trust.
- Sentara remains focused on their goals of excellence in patient care, across a full continuum of services, and excellence measured in terms of quality, costs and service (form follows function).

Sources: Sg2 Interview With Sentara, July 21, 2010; Sg2 ACO Roundtable Sessions, July 22, 2010; Brookings-Dartmouth ACO Learning Network Webinar, September 3, 2009.

Next Steps: Navigating the Transition

Deciding whether or not to begin the ACO journey requires a focused process involving key participants and an honest assessment of readiness, capabilities, barriers to success and opportunity costs.

1 Develop a shared vision.
- Determine your specific ACO approach—leader or fast-follower working on essential SoC competencies.
- Hospital leadership, key physician leaders, board members and payers must work together to design a vision of accountable care for the market.

2 Find the right starting place.
- Which providers, physician groups, employers and payers will serve as the best partners?
- Assess the market and competitive landscape.

3 Complete a comprehensive readiness and risk assessment.
- Perform an Sg2 Value Index analysis (see page 17).

4 Address potential barriers.
- HIPAA/privacy issues
- Federal and state law
- FTC approval processes
- Fraud and abuse statute, anti-kickback statute
- Competitive/market dynamics

5 Assess infrastructure needs and associated costs.
- IT system, EMR, registries, predictive modeling
- Legal entity
- Time: leadership, management, governance
- Analytics

6 Define leadership and governance structures.
- Physician-led structures
- Board of directors—roles and responsibilities
- Management team competencies—managing risk
- Reporting value
- Flexibility to allow for changes in participation and structure as the ACO evolves

7 Establish shared savings goals.
- Refine the metrics and define the savings allocation model.
- Finalize reporting requirements.
- Model expenditure scenarios.

8 Move toward implementation.

Focus your organization's resources and talent on building disease-based **Systems of CARE**...Differentiate your services by demonstrating your ability to **Create Value** for patients and payers.

HIPAA = Health Insurance Portability and Accountability Act; SoC = System of CARE.

Appendix
Essential System of CARE Competencies

Regardless of whether your organization chooses to take on an ACO pilot or not, you will need to begin the hard work today to develop the competencies and infrastructure necessary to compete in the reform era.

Today's Strategies for Improving Performance to Create Value

Deploy an IT system across the care continuum.	■ Use subsidies to accelerate physician EMR adoption. ■ Implement robust IT systems to improve clinical appropriateness. ■ Add tools at the disease level.
Use data and analytics to measure and monitor performance.	■ Quantify value to measure progress. ■ Capture financial opportunities through performance improvement. ■ Become proficient at predictive modeling and risk stratification.
Create strategic partnerships across the continuum.	■ Enhance strategic partnerships to improve care coordination. ■ Explore clinical integration to create performance differentiation. ■ Use performance measures to clinically integrate employed and independent physicians. ■ Address care coordination needs across the organization.
Reduce unnecessary admissions by targeting high-risk patient populations.	■ Analyze potentially avoidable admissions to target improvements in community-based care. ■ Use electronic health records and registries to initiate preventive care.
Develop the capability to track patient care and ensure follow-up.	■ Improve performance and efficiency with e-visits. ■ Utilize e-care to ensure continuous patient connectivity.
Build resources for patient education and self-management.	■ Improve performance with care coordinators. ■ Consider an integrated patient portal to improve quality of care.
Develop leadership skills to plan, organize and deliver clinically integrated care.	■ Keep clinical and administrative leaders focused along common goals. ■ Enable effective system decision making with distributed leadership.
Accelerate an implementation timeline for performance initiatives.	■ Focus on performance metrics that close the gap between value and strategy. ■ Prioritize implementation of performance improvement strategies.

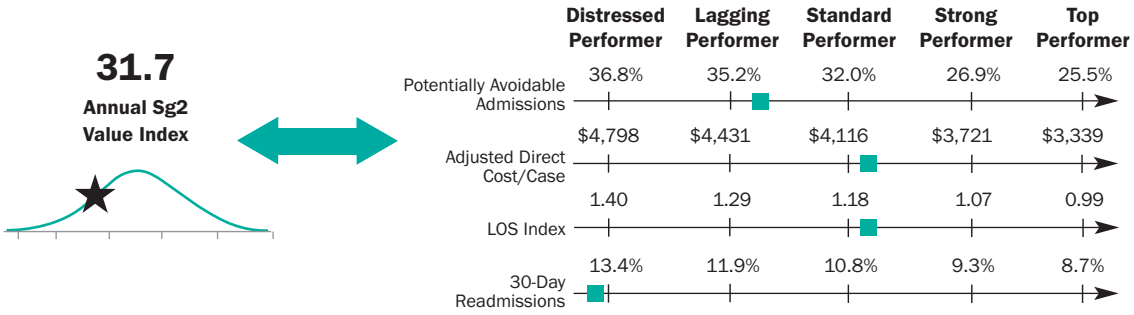
Appendix
Sg2 ACO Readiness Analytics

Payment reform and reimbursement changes will increasingly shift care to the outpatient setting while refocusing incentives on value, quality and performance. To succeed in the long-term, it is imperative that organizations look beyond the walls of the hospital to identify and prioritize vital performance indicators across the full care continuum.

Financial Opportunities Exist if Performance Can Be Improved

The Sg2 Value Index™ is a scoring system designed to help hospitals set performance improvement goals that will bring about measurable change. Scores are derived using key metrics that span the care continuum, including potentially avoidable admissions, length of stay, cost per case and 30-day readmissions. The Value Index also can be used to assess an organization's readiness to become an ACO. Monthly updates and 24-month trending analyses track the effectiveness of performance initiatives and provide comparisons against leading practices and peer hospitals in the Sg2 database.

Sg2 Value Index™ Summary for Sample Hospital A: Enterprise



Sg2 Value Index Metric	Contribution Impact if a Top Performer
PAA	$858,509
Adjusted* Cost	$32.8M
LOS Index	$4.4M
30-Day Readmission	$316,829

*Wage-adjusted, mix-adjusted direct cost.
Source: Sg2 INSIGHT™ Database, 2010.

Key Characteristics of the Sg2 Value Index

- Provides a "bond rating" for clinical performance
- Captures effectiveness of System of CARE performance
- Drives performance to meet today and tomorrow's needs (ACO, reform ready)
- Integrates clinical/operational/financial performance metrics into 1 score
- Enables action based on relevant peer comparisons
- Foundationally driven by disease-based analytics
- Grounded in leading-practice results criteria, including performance levels, trends, relative comparisons and integrated metrics

Appendix
Create a Growth Index to Monitor Performance

Creating a Growth Index provides you with a single score to measure smart growth across the care continuum. Over time, you can track how well you are capturing smart growth throughout your system and determine which smart growth areas to focus on. Your Growth Index will increase as you initiate programs to enhance growth across the enterprise. Monthly updates allow you to track progress and 12-month trending.

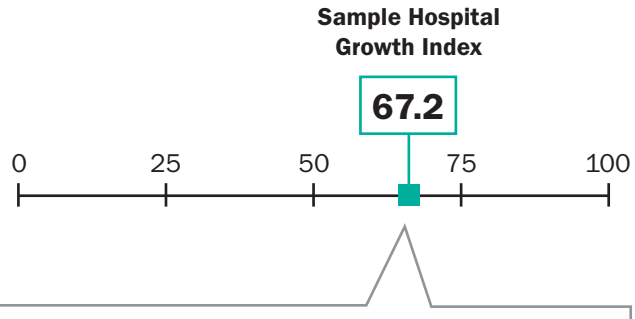
Growth Index Scores Help Answer: Are We Growing the Right Things?

The Sg2 Growth Index profiles your existing patient mix and illustrates how it influences your organization's ability to achieve profitable and sustainable growth. It examines your organization's rate of potentially avoidable admissions and 30-day readmissions to determine whether you have the necessary primary care infrastructure and care coordination processes to capture appropriate growth and lessen financial risk. As such, the Sg2 Growth Index serves as an impetus for discussing opportunities for investment, partnering and building to create your optimal System of CARE.

Sg2 Growth Index Methodology

Sg2 Growth Index is calculated at the enterprise and service line levels to prioritize key areas of opportunity.

$$\text{Growth Index} = \frac{\text{Smart Growth Discharges}}{\text{Total Discharges}}$$



A score of 67.2 means that 67.2% of the hospital's discharges meet the following criteria:

- **Non–potentially avoidable.** Non–potentially avoidable cases treated in the acute care setting. Potentially avoidable admissions are defined as inpatient hospitalizations that may be avoided through clinician diagnosis, education and treatment in the outpatient setting.
- **Non–30-day readmission.** Cases not readmitted to the hospital within 30 days of discharge.
- **Positive contribution margin.** Cases that generated a contribution margin (total net revenue minus total direct costs) greater than zero.

Calibrate Your Growth Index Score Monthly

Health care organizations are being challenged to grow in a manner that is not only profitable, but also clinically appropriate and supported by local community needs. When interpreting and calibrating your Growth Index, consider your current environment. For some hospitals, a Growth Index of 100 may be unattainable due to payer mix, the mission of the organization and the needs of the community. For others, a score close to 100 may be possible.

Growth Index Monthly Breakdown

	Jun 09	July 09	Aug 09	Sept 09	Oct 09	Nov 09	Dec 09	Jan 10	Feb 10	Mar 10	Apr 10	May 10	12-Mo
Growth Index	45.1	47.1	45.8	48.2	46.7	45.3	49.1	49.0	48.4	48.9	49.3	45.8	47.5

Note: Analysis excludes mom-baby, psychiatric and rehab patients.

Anticipate the Impact of Change

Sg2's analytics-based health care expertise helps hospitals and health systems integrate, prioritize and drive growth and performance across the continuum of care. Over 1,200 organizations around the world rely on Sg2's analytics, intelligence, consulting and educational services.

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