Operationalizing Accountable Care: Living in the Worlds of Medicare and Commercial ACOs

American Medical Group Association
Council of Attorneys
October 16, 2013
Overview

I. Overview
II. Synergy with Other Initiatives
III. ACO Organizational Structure/Implementation Issues
IV. Clinical Integration: Foundation of Accountable Care
V. Financial Models and Shared Savings Distribution
VI. Performance Monitoring and Quality Metrics
VII. Evolving Legal Standards
VIII. Lessons Learned from ACO Experience
IX. Questions
I. Overview
Setting the Stage

- Goals of the Medicare Shared Savings Program ("MSSP") as outlined in the MSSP Application:
  - Promoting Evidenced Based Medicine
  - Promoting Beneficiary Engagement
  - Report Internally on Quality and Cost Metrics
  - Better Care Coordination
Common Elements of Payment Reform

- Efficiency
- Transparency
- Decreasing Cost Trends
- Improved Quality
- Aligned incentives among providers of care
- Clinical and financial accountability
- Patient-centered
- Shifting of risk to providers

ACO

Hospital SNF
Physicians
Outpatient Clinics/Centers
Home Health Rehab
Behavioral Medicine Pharmacy
Clinical Integration – Aligning to Achieve the “Triple Aim™”
Accountable Care/Clinical Integration Roadmap

Destination:

- Hospitalist and Hospital-based Physicians
- Reduce Re-admissions
- Bundled Payment
- Patient-centered Medical Home
- Transactions/Network Development
- Clinical Integration
- Physician Enterprise Restructure
- System Wide Care Management Restructuring
- Physician Enterprise Restructure
- Hospital Case Management Improvement
- Clinical Co-management
- Patient Safety and Throughput
- Physician Relationships/Leadership Development

Fee-for-Value
Fee-for-Service
Evolving Leadership Requirements

Key Leadership Requirements

Fee-for-service

“Lean” Management
Vision
Seek Growth

Fee-for-Value

Patient Safety
Throughput
Hospitalist and Case Management

Transition

Reduce Re-admissions
Clinical Co-management

Change Management
Communication

Value-based Clinical Transformation
Clinical Integration
Care Management
Medical Home

Fee-for-service

Fee-for-Value

Collaboration
Transparency
## Healthcare Transformation: What’s the Velocity of Change?

### Risk-based Contracts
- Cost shifting to employees
- Employer impatience with rising costs
- Federal and state budget cuts
- Narrow networks
- Mergers and acquisitions
- Supreme Court decisions

### Health Information Exchange
- Coverage Expansion
- Value-based Purchasing
- Meaningful Use Compliance
- Large Medical Group Practice Consolidation
- Clinical protocol adoption

### Fully Functioning Clinically Integrated Networks
- Full population-driven healthcare management
- Payment transformation (no more FFS)
- Cultural transformation
- Medical education Reform

### SHORT-TERM
- 1-2 Years
- 

### MEDIUM-TERM
- 2-5 Years
- 

### LONG-TERM
- 10+ Years
- 

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Adapted from “Understanding the Velocity of Change in Healthcare” by I. Morrison, *H&HN Daily*, 2012
### Growth and Dispersion of ACOs

<table>
<thead>
<tr>
<th>Organization Type</th>
<th>Number of Organizations</th>
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<tbody>
<tr>
<td>Commercial ACOs</td>
<td>161</td>
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<tr>
<td>Medicare Pioneer ACOs</td>
<td>32</td>
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<tr>
<td>MSSP ACOs</td>
<td>222</td>
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<tr>
<td>Health Information Exchanges</td>
<td>206</td>
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</tbody>
</table>

- ACOs have spread to 49 states, Washington DC, and Puerto Rico
- California, Florida, and Texas have most 46, 42, and 33 ACOs
- Approximately half of all Medicare ACOs are physician-led
- Most extensive ACO growth throughout Midwest and West Coast in larger population centers
- Hospital systems are primary backers of ACOs; physician groups playing larger role
- Non-Medicare ACOs are experimenting with more diverse models
- Success of any ACO model is still undetermined

Growth and Dispersion of ACOs

- Hospital Referring Regions ("HRR") are geographic regions defined by the Dartmouth Institute for Health Policy and represent markets where patients are likely to be referred for tertiary care.
- HRRs are regions where ACOs are likely to compete for patients.

Accountable Care Potential Market Segments

- Enlarging the Pie
Discuss Differences of Commercial vs. Medicare ACOs

- Commercial
  - Payer defined quality metrics
  - Certain products only
  - Patient identification and steerage
  - Payer data
  - Often have utilization metrics as well as quality
  - Defined patient population
  - Lacks regulatory framework of Medicare programs

- Medicare
  - Organizational structure defined by regulation
  - Thirty-three CMS defined quality metrics
  - Shared savings payment model
  - Waivers for Fraud and Abuse laws
II. Synergy with Other Initiatives
Driving the Value Proposition

Integration

Low

High

Limited

Full

Impact on Value

- Managed Care
- Shared Risk
- Bundled Payments
- Clinical Integration

- Specialty
- Co-management
- Medical Home

- COE/Specialty Institutes
- Medical Foundation
- Physician Employment
- RHC, FQHC, Community Clinics

- Accountable Care
- IDN/Health Plan

- Medical Home
- Bundled Payments
- Clinical Integration
- Accountable Care
- IDN/Health Plan
Bundled Payment Models

Continuing Expansion and Evolution

- New payment method (will be used with Medicare, Medicaid, and commercial payers)
- One payment for physician, hospital, and post-acute care services (30 or 60 day period)
- Economic incentives: “savings” can be shared with physicians
- Payment is “per case” (at a discount from current rates)
  - Medicare – no steerage
  - Commercial – tiered pricing equals steerage

Model One  Model Two  Model Three  Model Four  Model 25?
Patient-Centered Medical Home

- Focus on Patient Centeredness and Patient Experience
- Three of seven principles directly address the Patient Experience

- Whole Person Orientation
- Physician Directed Medical Practice
- Care Coordination
- Enhanced Access
- Quality and Safety
- Payment
The Traditional Primary Care Practice Model Is Changing

Past

Single or small group practice primary care clinic no longer economically sustainable.

Future

Patient Centered Medical Home

Health coach works collaboratively with physicians, staff, and other professionals to coordinate care across the continuum

Center for Chronic Care Management

Members of PHO

Diabetes Care Team
- RN (CDE²)
- Registered dietitian (CDE)
- Diabetes Navigator
- Community Health Outreach worker

EMR
- Shared patient medical record
- Shared scheduling system
- Secure message between providers
## Evolving From → To

<table>
<thead>
<tr>
<th>From</th>
<th>To</th>
</tr>
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<tbody>
<tr>
<td>Pay for procedures</td>
<td>Pay for value</td>
</tr>
<tr>
<td>Fee-for-service</td>
<td>Case rates/budgets/capitation</td>
</tr>
<tr>
<td>More facilities/capacity</td>
<td>Better access to appropriate settings</td>
</tr>
<tr>
<td>Physicians/Hospitals acting independently</td>
<td>Physicians/Hospitals collaboration:</td>
</tr>
<tr>
<td></td>
<td>global risk</td>
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<tr>
<td>Physicians and Hospitals working in parallel</td>
<td>Physicians and Hospitals working in a</td>
</tr>
<tr>
<td></td>
<td>highly integrated manner</td>
</tr>
<tr>
<td>Hospital centric</td>
<td>Continuum of Care (Population centric)</td>
</tr>
<tr>
<td>Treat disease/episode of care</td>
<td>Maintain health</td>
</tr>
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[https://sharepoint.thecamdengroup.com/Clients/Providence_Health_System/Providence%20Health-Burbank/Presentation/Camden_10_HC_Trends_2013_03_01_13.pptx](https://sharepoint.thecamdengroup.com/Clients/Providence_Health_System/Providence%20Health-Burbank/Presentation/Camden_10_HC_Trends_2013_03_01_13.pptx)
III. ACO Organizational Structure/Implementation Issues
Rethinking Our Organizational Orientation
CI/ACO Business Model Process

Phase 1: Structure Development
- Craft action plan
  - Milestones
  - Interim strategies
  - Potential structures
  - Governance models
- Identify required resources
- Create organizational structure
- Set-up governance
- Define participation criteria
- Design care management structure
- Establish clinical protocol priorities

Phase 2: Population Management
- Identify IT vendor/action plan
- Establish clinical outcomes
  - IT resources
  - Physician leadership
  - Care management
- Create network and identify payer contracting opportunities
- Draft definitive business plan
  - Identify plans for interim as well as long-term strategy

Phase 3: Market Value to Payers
- Establish entity
- Develop protocols/measures
- Implement IT
  - Process for collecting and monitoring clinical results
  - Begin data collection
- Implement related strategies
  - To be determined by organization
- Establish payer relationship(s)
Organizational Structure: For-profit or Not-for-profit

For-profit Structure

- At the end of the year, CI/ACO joint venture would have to distribute all funds rather than retain reserves
- Easier to structure from a legal standpoint
- Would be preferred by independent physicians/practices, which are for-profit
- For-profit LLC, rather than C-corp, would not add a layer of taxation

Not-for-profit Structure

- There are more regulatory issues to meet
- Would require at least 51 percent ownership by Health System
- May provide a more positive image in community for the CI/ACO joint venture
- Not a true representation of how the company is likely to be operated
# Organizational Models for CI

<table>
<thead>
<tr>
<th>Model</th>
<th>Characteristics</th>
<th>Pros</th>
<th>Cons</th>
<th>Legal Structure</th>
</tr>
</thead>
</table>
| Nonprofit JV LLC | - Liability of members limited to capital contributions  
 | - Flexibility in allocation of tax profits/losses, distributions of cash  
 | - Generally, may be less formally governed | - CI/ACO activities would be a related activity to the exempt purpose of a tax-exempt hospital member  
 | - Hospital can fund disproportionate share of capital expenses, but still have substantial physician involvement in governance  
 | - Responsive to Hospital mission and need for greater physician involvement  
 | - Provides clear lines of accountability and financial transparency  
 | - Hospital and physicians have equal partnership on risk and pay for performance contracts | - Risk of jeopardizing tax-exempt entity’s tax-exempt status where CI/ACO also includes for-profit members  
 | - Physicians may resist participation where Hospital is dominant member  
 | - Implications if the offering of stock constitute the sale of a security under federal or state laws  
 | - Schedule K-1 filing obligation | - CI/ACO ownership interests and profit distributions need not be directly proportional to capital contributions  
 | - Would require at least 51 percent ownership by Hospital  
 | - May provide a more positive image in community for the CI/ACO joint venture  
 | - Not a true representation of how the company is likely to be operated |
| Nonprofit Tax-exempt | - Income is tax-exempt to the CI/ACO  
 | - Simultaneously responsive to Hospital mission and need for greater physician involvement  
 | - Provides clear lines of accountability and financial transparency  
 | - Hospital and physicians have equal partnership on risk and pay for performance contracts | - If exemption not available, net income will be taxable  
 | - Difficult to have Hospital as sole member but have sufficient physician involvement in governance under “integral part test”  
 | - Cost and time involved in obtaining tax-exempt status for CI/ACO  
 | - Physicians may resist participation where Hospital is dominant member | - Furtherance of tax-exempt participant’s charitable purpose  
 | - In tax-exempt hospital-physician joint venture, benefits flow to hospital (not physicians) consistent with its tax exempt status  
 | - Tax-exempt representation on board commensurate with level of investment; veto power; control over charity care and community benefit; community needs assessments; participation in Medicaid |

Sources: Ropes & Gray; Davis Wright Tremaine LLP; The Camden Group
Possible Structures

ACO

Physicians

Ownership

Hospital

Contracting with Payers

ACO

Physician Members

Contracted

Independent Physician Owners

Physician Organization

Contracted

Health System

Health System

ACO Organization

Contracted
Sample ACO Configuration

Medicare/Other Payers

Accountable Care Organization
- Medical Group
- Foundation
- IPA

Management Services Agreement

Infrastructure (Provided or Contracted ACO Operations)
- Information Technology
  - EMR, CPOE, PACS
  - Data warehouse
  - Reporting
- Care Management
  - Hospitalists and Intensivists
  - CMO
  - Disease management
  - Clinical protocols
  - Advanced analytics and modeling
  - Call center
  - Utilization management
  - Knowledge management
- Health Network
  - Delivery network
- Financial/Payment Systems

Physician Network
- Medical Group(s)
- Community MDs

Hospitals
- Hospitals
- Other Regional Hospitals?

Continuum of Care Services
- Outpatient services
- Nursing homes
- Home health
- Acute rehab
- Hospice
- Other

Joint Ventures
- Hospitals
- Other Regional Hospitals?
ACO Structure: Nonprofit, Taxable Subsidiary of System

Medicare Advantage and Other At-Risk Payers

Medicare FFS, Non-risk Payers

Insurance Arm

Health System

ACO Non-profit, Taxable

System Health Network

- Network development
- Credentialing
- Provider contracting
- Non-risk payer contracting

System for Other Infrastructure Services

- IT
- Care management
- Finance/Payment system
- Other

Providers

- Acute care hospitals
- Physicians
- Acute rehab
- LTAC
- Home health
- Outpatient departments
- Others along continuum of care

MSA

MSA

MSA

Provider contract

$
Options for Infrastructure Funding

- Health System partner
- Equity venture
- Shared savings
  - Pay infrastructure costs prior to any distributions
- Member assessment
- Investor options (For-profit)
Key MSSP Requirements

- **Governing Body (425.106(c)(2))**
  - Beneficiary Representative from Medicare Fee-for-Service population

- **Conflict of Interest Policy (425.106(d))**
  - Governing Body must disclose relevant financial interests, institute a procedure to evaluate any conflicts and provide for remedial action for failure to comply

- **Senior Level Medical Director: (425.108(c))**
  - Board-Certified Physician in State where ACO operates, physically present on regular basis at location participating in ACO

- **Quality Assurance Program, Written Standards for Records Access (425.112)**
Key MSSP Requirements

- Compliance Plan: (425.300)
  - Designate a Compliance Officer (Not Legal Counsel)

- Marketing: File and Use - "Deemed Approved"-after expiration of 5-day review period (425.310(b))

- CMS Right to Audit Records (425.314(a))

- Maintain Records - 10 years (425.314(b))

- 33 Quality Metrics (425.500)

- Provide form for Data Opt-Out at First PCP Appointment (425.708(b))
Key MSSP Implementation Issues

- Notification Mailing to Beneficiaries
  - Data Sharing letter to MSSP Beneficiaries response to drug/alcohol
  - Opt-out percentages - one to three percent in Premier Collaborative
  - CMS marketing rules for educational materials for beneficiaries

- Evaluating CMS claims data
  - Monthly beneficiary data sharing status file
  - Fluid nature of MSSP beneficiaries (beneficiaries moving in and out of attributed population)

- Roll-out
  - Beneficiary notification—are you just another HMO? Why does Big Brother need my information? Are you going to raise my rates with this information?
  - Office posters
  - Compliance training
IV: Clinical Integration: Foundation of Accountable Care
New Care Delivery Along the Continuum: Delivery Network

- Hospitals
- Medical Group
- Health Plan
- Ambulatory and Community
- Post-acute

System Integrated Care

Continuum of Care
Clinical Integration Building Blocks

- Improved Quality and Access
- Reduce Costs and Waste

Finance/Managed Care
- Value-based Payment Models
- Funds Flow Distribution

Delivery Network
- Expand Primary Care Base
- Strengthen Partnerships Along Continuum
- Define Membership Criteria

Care Model/Information Technology
- Care Management
- Population Health Management
- Clinical Data Repository
- Data Analytics

Organizational Structure
- Physician Leadership
- Entity Formation
- Change Management
- Establish Governance

The Camden Group | 7/01-03/2013
Care Delivery Model: Key Components

- Clinical care model spanning full continuum of care
- Clinical infrastructure and leadership
- Clinical guidelines
- Process for protocol development

- Functional scope
- Ownership structure
- Leadership
- Decision-making
- Operational structure

- Financial operating model
- Resource and staffing requirements
- Capitalization needs

- IT infrastructure to connect key data sources across the continuum
- Centralized data repository
- Analytics capacity to report quality across the network

- Key operational performance metrics
- Clinical quality outcomes
- National standards
Care Management Process

Patient identification through:
- Population stratification
- Clinical qualifiers
- Disease states
- Frailty
- Coordination needs

Patient engagement at:
- Home
- Hospital, SNF
- Care transitions
- Telephonic

Patient outreach when:
- New patient
- After PCP visit
- 30 days post-acute
- New diagnosis
- New prescription

Source: The Camden Group
Patient Management Between Levels of Care

Hospice/Palliative Care
End-of-life patients, focus is palliative versus curative.

Home Care Management – End Stage
Provides in-home medical and palliative care management by Specialized Physicians, Nurse Care Managers, and Social Workers for chronically frail seniors that have physical, mental, social, and financial limitations that limits access to outpatient care, forcing unnecessary utilization of hospitals.

High-risk Clinics and Care Management
Intensive one-on-one physician/nurse patient care and case management for the highest risk, most complex of the population. As the risk for hospitalization is reduced, patient is transferred to Level 2. Physicians and CMs are highly trained and closely integrated into community resources, physician offices, or clinics.

Complex Care and Disease Management
Provides long-term whole person care enhancement for the population using a multidisciplinary team approach. Diabetes, COPD, CHF, CKD, Depression, Dementia.

Self-management, PCP
Provides self-management for people with chronic disease.

Population Monitoring
Preventive care, education, and monitoring for the community.
Clinical Integration Structure

- Hospital/Health System
- Physicians
- CI, LLC
- Infrastructure
- PCP
- SPC
- Ancillaries
- Facilities/Post-acute
- Pharmacy
Typical State CI IT Platform

User Community

Providers EMR
Providers Non-EMR
Hospitals Urgent Care LTC
Care Managers
Patients

Provider & Patient Portal

Analytics & Reporting
- Population Health Identification
- Stratification
- Gaps in Care
- Reporting
- Clinical/Performance
- Financial, Administrative
- Reimbursement
- Shared Savings

Workflow Tools
- Secure Messaging, Referrals, Order Entry, Alerts,
- Transitions of Care, Med. Lists
- Patient Education and Outreach

CENTRAL DATA REPOSITORY (CDR)
- Enterprise Master Patient Index (EMPI)
- Data Code Normalization Mapping (LOINC, SNOMED)
- Longitudinal Patient Record

Health Information Exchange (HIE)

Facilities
- Hospitals
- Urgent Care
- LTC

Providers
- EMR
- PMS

Community
- Lab
- DME
- Rx
- Rad
- Claims

Patients
- PHR

Data Sources
IT Platform: Critical Success Factors

What Are Others Finding Important?

**HIE/CDR**
- Ability to integrate, normalize, and exchange all relevant data
- Generate a comprehensive, longitudinal patient record

**Provider and Patient Tools**
- Single point of entry
- Robust workflow tools
- Comprehensive common data set shared among all providers

**Reporting Tools**
- Ability to report on all clinical and financial data in order to evaluate effectiveness of interventions
- Evaluation of outcomes related to goals and causality

**Population Health Analytics**
- Population/Patient-level identification, stratification, disease registry

**Care Management**
- Working from same patient information as the providers
- Care plans generated from assessments and evidence-based guidelines
- Care plan workflow integrated into provider and patient tools

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Network Build Dashboard (Status Report Date)

<table>
<thead>
<tr>
<th>Voluntary Recruitment by Specialty</th>
<th>Voluntary Recruitment by Geography</th>
<th>Large Medical Groups</th>
<th>Employed Physicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employed</td>
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<td>Large Medical Groups</td>
<td>Employed Physicians</td>
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<tr>
<td>Voluntary</td>
<td>Voluntary</td>
<td>40 Callen-Lorde</td>
<td>1,134 Total</td>
</tr>
<tr>
<td>Total</td>
<td>Total</td>
<td>23 Institute for Family Health</td>
<td>577 Beth Israel</td>
</tr>
<tr>
<td>85% of goal</td>
<td>95% of goal</td>
<td>20 Village Care</td>
<td>517 St. Luke’s - Roosevelt</td>
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<td></td>
<td></td>
<td></td>
<td>40 New York Eye and Ear</td>
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</table>

**Voluntary Recruitment by Specialty**

- 76 Primary Care
  - 13 Family Practice
  - 54 Internal Medicine
  - 9 Pediatrics

- 405 Specialists
  - 8 Allergy
  - 23 Cardiology
  - 22 Dermatology
  - 24 Ear/Nose/Throat
  - 47 Gastroenterology
  - 16 Gen Surgery
  - 16 OB/GYN
  - 11 Orthopedics
  - 83 Ophthalmology
  - 97 Other Medical
  - 50 Other Surgical
  - 8 Pain

**Voluntary Recruitment by Geography**

- 343 Manhattan
  - 46 Uptown
  - 147 Midtown
  - 150 Downtown

- 99 Brooklyn

- 2 Bronx

- 20 Queens

- 2 Long Island

- 5 New Jersey

- 7 North Suburbs

- 3 Staten Island

**Large Medical Groups**

- 40 Callen-Lorde
- 23 Institute for Family Health
- 20 Village Care

**Employed Physicians**

- 1,134 Total
- 577 Beth Israel
- 517 St. Luke’s - Roosevelt
- 40 New York Eye and Ear

**Hospital-based Voluntary Physicians**

- 234 Total
- 88 Radiology
- 146 Anesthesiology

**Total Physicians:**

- 1,932
V. Financial Models and Shared Savings Distribution
Funds Flow On The Way In

- Operational expenses including:
  - Salaries
  - Overhead
  - Physician Stipends
  - IT and Analytics
  - Enablements Structure Costs
  - Reserve accrual over time

- Revenue may include (C = Commercial; M = MSSP)
  - Operational payments from the Payers such as a payment for completing a Health Risk Assessment (C)
  - PCP Care Management Fee (C)
  - P4P = Pay for Performance based on a clinical/quality outcome (C)
  - Shared Savings based on financial target(s) (C) (M)
Funds Flow Distribution

Payment to Healthcare Providers at usual rates

Medicare rates

CI Organization Contracts with Payers

Operational Payment

Shared Savings

P4P

Revenue Collected by CI Organization

Expenses (Including Care Management Fee, Reserves)

Funds for Distribution
Funds Flow Steps

1. How many funds are available for distribution

2. Distribution among owners
   - PCP = X%, SCP = Y%, Hospital = Z%, Other __

3. Gainshare Formula Component Percentages (Citizenship, Process + Clinical)

4. ACO to determine initiatives, metrics and minimum criteria
Distribution to Providers

- PCPs: X %
  - Minimum Criteria and Distribution formula to be developed

- SCPs: Y %
  - Minimum Criteria and Distribution formula to be developed

- Hospital: Z %
  - Minimum Criteria and Distribution formula to be developed
Examples of Distribution Models:
Variety of Models, but Common Framework

<table>
<thead>
<tr>
<th>System A</th>
<th>System B</th>
<th>System C</th>
<th>System D</th>
<th>System E</th>
<th>System F</th>
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</thead>
<tbody>
<tr>
<td><strong>ACO Type</strong></td>
<td>Commercial</td>
<td>Commercial</td>
<td>Medicare</td>
<td>Medicare</td>
<td>Medicare, Commercial</td>
</tr>
<tr>
<td><strong>Distribution metrics</strong></td>
<td>Quality, Efficiency</td>
<td>Quality, Efficiency</td>
<td>Utilization, Quality</td>
<td>Utilization, Quality, Patient satisfaction</td>
<td>Utilization, Quality, Patient satisfaction, Efficiency</td>
</tr>
<tr>
<td><strong>Hospital: Physician split</strong></td>
<td>15% Hospital / 85% Physician</td>
<td>25% Hospital / 75% Physician after ACO costs</td>
<td>20% Hospital / 80% Physician</td>
<td>50 Hospital / 50 Physician after 15% for ACO costs</td>
<td>66.6% Hospital / 33.3% Physician 50% of Hospital goes to Network infrastructure / 50% to continuum of service</td>
</tr>
<tr>
<td><strong>Specialist: PCP split</strong></td>
<td>56% SCP / 44% PCP</td>
<td>30% SCP / 70% PCP</td>
<td>25% SCP / 75% PCP</td>
<td>50 SCP / 50 PCP</td>
<td>0% SCP/ 100% PCP (Only PCP are eligible at this time)</td>
</tr>
<tr>
<td><strong>Provider Measure split</strong></td>
<td>Quality 50% / Efficiency 50%</td>
<td>Specialist: Quality 65% / Efficiency 35% PCP: Quality 35% / Efficiency 65%</td>
<td>Process, Pat Sat &amp; Outcomes 60% / Utilization-40%</td>
<td>Quality 40% / Pt Sat 40% / Utiliz 20%</td>
<td>Y1 Quality 50% / Utilization 50%</td>
</tr>
<tr>
<td><strong>Physician or Group Payment</strong></td>
<td>Individual provider payments</td>
<td>Individual provider payments</td>
<td>Provider group payments</td>
<td>Individual provider payments</td>
<td>Individual provider payments</td>
</tr>
</tbody>
</table>

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VI. Performance Monitoring and Quality Metrics
MSSP ACO Quality Measures

- Thirty-three total quality measures in four domains:
  - Patient/caregiver experience (7 measures)
  - Care coordination/patient safety (6 measures)
  - Preventive health (8 measures)
  - At-risk population:
    - Diabetes (6 measures)
    - Hypertension (1 measure)
    - Ischemic Vascular Disease (2 measures)
    - Heart Failure (1 measure)
    - Coronary Artery Disease (2 measures)

- Commercial Shared Savings programs often align with these metrics
Analytics and Reporting

Measure Success

- Track and trend performance
  - Reporting/quality measurement at the entity, group, and individual physician level
  - Report should be available to improve physician behavior such that consequences exist

- Program ROI

- Metrics might include:
  - Bed days
  - Readmission rates (30, 60, 90 days)
  - Total cost of care
  - Acute costs, LOS
  - Sub-acute costs, LOS
  - Pharmacy costs
  - Number of PCP visits per year
  - Medication adherence
  - Clinical quality metrics
  - Patient satisfaction scores
MSSP Quality Performance Scoring

- First performance year: ACO eligible for maximum sharing rate if ACO generates sufficient savings and successfully reports the required quality measures

- Subsequent years: ACO must successfully report quality measures and will be assessed on performance

- Pay-for-Performance phasing:
  - Year 1: Pay-for-reporting applies to all 33 measures
  - Year 2: Pay for performance applies to 25 measures. Pay for reporting applies to 8 measures
  - Year 3: Pay-for-performance applies to 32 measures, Pay for reporting applies to 1 measure
### Methods of Data Submission

<table>
<thead>
<tr>
<th>Number of Measures</th>
<th>CMS Claims and Administrative Data</th>
<th>ACO GPRO Web Interface</th>
<th>Patient Experience of Care surveys</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>4</td>
<td>22</td>
<td>7</td>
</tr>
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#### Details

- **No ACO involvement.** Centers for Medicare and Medicaid Services (“CMS”) ACO Program Analysis Contractor coordinates with CMS to obtain Medicare claims and electronic health record (“EHR”) files.
- **Nearly identical to portal used in Physician Quality Reporting System (“PQRS”) Group Practice Reporting Option.** Pre-population database with assigned beneficiary sample will serve as data collection tool.
- **CMS will initially administer and pay for survey.** After first two years in MSSP, ACOs must select a CMS-certified vendor to administer the patient survey.
SSP Quality and Performance Payment

Pay-for-Performance Calculations

### Quality Domains

<table>
<thead>
<tr>
<th>Domain</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient/Caregiver Experience</td>
<td>25%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care Coordination/Patient Safety</td>
<td></td>
<td>25%</td>
<td></td>
</tr>
<tr>
<td>Preventive Health</td>
<td></td>
<td></td>
<td>25%</td>
</tr>
<tr>
<td>At-Risk Populations</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Weighting

<table>
<thead>
<tr>
<th>Measure Type</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pay for Reporting</td>
<td>33/33</td>
<td>8/33</td>
<td>1/33</td>
</tr>
<tr>
<td>Pay for Performance</td>
<td>0/33</td>
<td>25/33</td>
<td>32/33</td>
</tr>
</tbody>
</table>
# Qualification for Shared Savings Distribution: Hurdle Metrics

<table>
<thead>
<tr>
<th>Incentives</th>
<th>Hurdle Metrics</th>
</tr>
</thead>
<tbody>
<tr>
<td>All metrics must be compliant to participate in Bonus Savings Pool</td>
<td>1. High-speed internet connection</td>
</tr>
<tr>
<td></td>
<td>2. Clinical Integration software training</td>
</tr>
<tr>
<td></td>
<td>3. Access Care Model and Metric Software and review quality data at least once a month</td>
</tr>
<tr>
<td></td>
<td>4. Attend membership meetings (one annual meeting)</td>
</tr>
</tbody>
</table>
**Sample Metrics: Primary Care Physicians/Internal Medicine**

<table>
<thead>
<tr>
<th>Metrics</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Experience</strong> (CG-CAHPS) 30%</td>
<td>Getting timely care, appointments, and information</td>
</tr>
<tr>
<td></td>
<td>How well your doctors communicate</td>
</tr>
<tr>
<td></td>
<td>Patient rating of doctor</td>
</tr>
<tr>
<td><strong>Quality</strong> 35%</td>
<td>A1C below 8</td>
</tr>
<tr>
<td></td>
<td>LDL &lt; 100 in Diabetics/CAD</td>
</tr>
<tr>
<td></td>
<td>Smoking cessation and follow-up</td>
</tr>
<tr>
<td></td>
<td>Flu vaccine</td>
</tr>
<tr>
<td></td>
<td>Colorectal screening</td>
</tr>
<tr>
<td></td>
<td>Medication reconciliation: reconciliation after discharge from an inpatient facility, ED, or specialist</td>
</tr>
<tr>
<td><strong>Network Efficiency</strong> 35%</td>
<td>Follow-up appointment post discharge from and inpatient facility</td>
</tr>
<tr>
<td></td>
<td>Health risk assessment</td>
</tr>
</tbody>
</table>
## Sample Metrics: Medical Specialists

<table>
<thead>
<tr>
<th>Metrics</th>
<th>Patient Experience 30%</th>
<th>Quality 35%</th>
<th>Network Efficiency 35%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Communication with doctors domain performance</td>
<td>Readmission - all cause</td>
<td>LOS</td>
</tr>
<tr>
<td></td>
<td>Doctors treat with courtesy/respect</td>
<td>Documentation of current medications in the medical record</td>
<td>Transition of care</td>
</tr>
<tr>
<td></td>
<td>Doctors listen carefully to you</td>
<td>Mortality rate</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Doctors explain in way you understand</td>
<td>Medication reconciliation at discharge</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Smoking cessation and follow-up</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hospital acquired infection rates</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
VII. Evolving Legal Standards
Legal Guidelines

- CMS/OIG Waivers under Fraud & Abuse Laws (as granted by under Section 3022(f) of the Affordable Care Act)

  - Five Waivers:
    - Pre-Participation
      - Start-up costs related to MSSP participation
    - Participation
      - ACO expenses during term of participation in MSSP
    - Patient Incentive
      - ACO offering medically-related incentives to encourage preventative care and treatment compliance
    - Shared Savings Distribution
      - Distributions of Shared Savings earned by ACO
    - Stark Law
      - Specific exception for arrangements that would otherwise implicate the Stark law
Legal Guidelines (cont’d)

- CMS/OIG Waivers
  - Waivers apply only to MSSP participation (not to Commercial program)
  - Waivers self-implementing/no need to apply to CMS
  - ACO Governing Body must make determination that arrangement reasonably related to MSSP program
  - Must maintain documentation of arrangement and Governing Body approval for ten years
Legal Guidelines (cont’d)

- Antitrust
  - Market Share Analysis
    - MSSP ACOs will be viewed by Antitrust agencies as being clinically integrated to allow participants to jointly negotiate commercial contracts subject to market impact
    - Safety zone applies if less than 30 percent common-service market share
    - Over 30 percent common-service market share will be reviewed on Rule of Reason analysis to examine procompetitive benefits of ACO
    - Voluntary and expedited antitrust review available for ACOs with above 30 percent common-service market share
      - No Mandatory Review as originally proposed in Interim Rule
Legal Guidelines (cont’d)

- IRS
  - No net earnings may inure to benefit private parties
  - Terms of agreement must be negotiated at arms-length
  - ACO ownership interests must be proportionate to the owner’s capital contribution and all returns/distributions must be proportional to an owner’s capital contributions
  - All contracts/transactions must be Fair Market Value
VIII. Lessons Learned from ACO Experience
ACO Challenges

- Speed of Transformation
  - Avoiding going too fast or too slow

- Clinical Cultural Transformation
  - Physician Workforce

- Communication
  - Strategy needs to resonate to create an engaged provider base
  - Information needs are different than before
ACO Challenges

- Integration
  - Current payment system means incentives still do not align
  - Different needs for PCPs, specialists, hospitals, insurance
  - Open model means many different IT platforms

- Willingness of Commercial Payers
  - Concern that true partnership will be difficult for a large payer segment
Lessons Learned

- To truly achieve Care Delivery redesign, ACO needs to be Physician-led
- Need to navigate carefully the balance between PCPs/Specialists and their respective contributions to the ACO
  - Patients are attributed to Primary Care Providers
  - Specialists also important – complex care but can also drive unnecessary costs
- Design achievable Conditions of Participation and enforce these requirements in order to drive behavior modification
- To ensure compliance with metrics, need to create dashboards or other measures to keep Physicians informed of progress
Lessons Learned (cont’d)

- Need to move toward risk-based payment system to ensure accountability of providers
- Design employed physicians compensation model redesigns to build synergy between ACO goals and physicians compensation
- Work to move commercial payer community to value-based reimbursement models to accelerate the transition between FFS and value-based worlds
- Find and retain the Care Managers necessary to facilitate the coordination of care required to best manage your patient populations
IX. Questions?
## Speakers

<table>
<thead>
<tr>
<th>Photo</th>
<th>Name</th>
<th>Title</th>
<th>Organization</th>
<th>Phone Number</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image" alt="Robert A. Gerberry Esq." /></td>
<td>Robert A. Gerberry Esq.</td>
<td>Associate General Counsel</td>
<td>Summa Health System</td>
<td>330.375.7515</td>
<td><a href="mailto:gerberrr@summahealth.org">gerberrr@summahealth.org</a></td>
</tr>
<tr>
<td><img src="image" alt="Tere Koenig, M.D., M.B.A." /></td>
<td>Tere Koenig, M.D., M.B.A.</td>
<td>Senior Vice President</td>
<td>The Camden Group</td>
<td>310.320.3990 ext. 3972</td>
<td><a href="mailto:tkoenig@thecamdengroup.com">tkoenig@thecamdengroup.com</a></td>
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