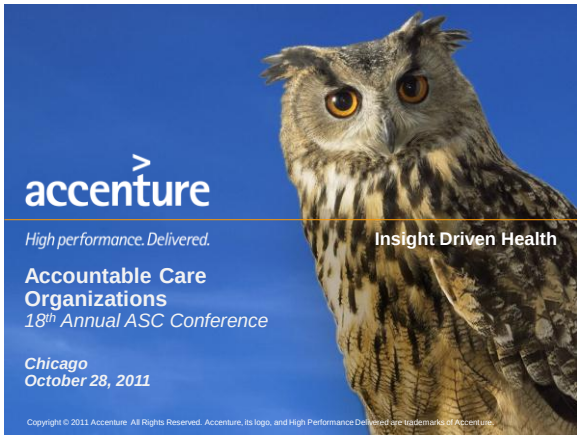

Overview

- Review of payment reform and ACO fundamentals
  - Current industry perspectives and insights
  - Core capabilities needed to support ACO-like organizations and payment structures
- Case Study: The Henry Ford Physician Network
- Impact of ACO's on ambulatory surgery centers

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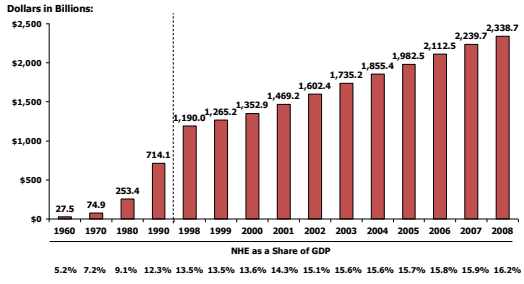
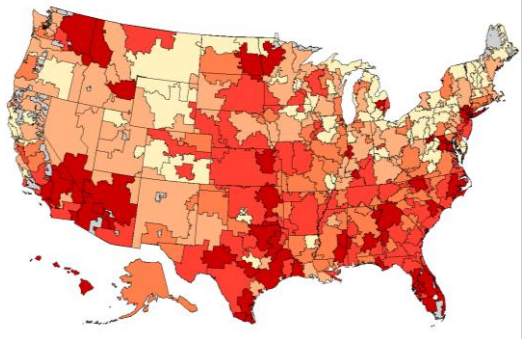
National Health Expenditures and Their Share of Gross Domestic Product, 1960-2008



Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, at http://www.cms.hhs.gov/NationalHealthExpendData/ (see Historical; NHE summary including share of GDP, CY 1960-2008; file nhegdp08.zip).

Geographic Variation in Screening for Prostate Cancer



Four Primary Market Forces are Driving Payment and Delivery Reform

- Prevalence of diabetes projected to increase 14% to 21% of US adults by 2050 - costs of those with diabetes estimated to **2.3 times greater**
- Across 6 common chronic conditions - Asthma, CAD, CHF, COPD, Diabetes, and Hypertension, "**potentially avoidable complications** account for 40¢of every $1 in healthcare spending"

Unsustainable Healthcare Expenditures

- The U.S. **leads the world in healthcare spending** – today 17 % of the U.S. GDP
- Healthcare expenditures **could reach 34% of GDP** by 2040 (Medicare & Medicaid 15%)
  - Only 25% attributable to the aging of the population and other demographics. 7**5% due to rising health care costs**

Increased Prevalence of Costly Preventable, Chronic Conditions

Payment & Delivery Reform

Need to Optimize & Standardize Quality Frameworks

- Patients with the same chronic illnesses **receive different care**
  - Primary care visits/ Medicare enrollee varies by a factor of ~3
  - Visits to medical specialists by > 5 and hospitalizations for CHF and COPD > 4
  - Spending varies by a factor of ~ 3
- Attributed to "supply sensitive care," **greater service availability leads to greater utilization**

Growing Recognition of Variation in Care Delivery

- The healthcare system is saturated with **more than 100 P4P programs** that are not standardized and do not focus on relevant measures of clinical outcome
- **Quality remains a top priority** for both providers and payers

Payment Models are Evolving

PAYER $ RISK → $ RISK PROVIDER

	Traditional FFS	FFS Shared Savings	Episodic Bundling	Global Payment	Traditional Capitation
Base Payment	Provider(s) paid on the basis of volume of services • Provider bills separately for each service performed • Currently the most commonly used payment system by providers	Group of providers paid on a FFS basis who deliver care against a preset budget to determine shared savings • Primary payment mechanism for Medicare Shared Savings program • Considered a "stepping stone" to more widespread use of bundled and global payments	Bundled payment for some or all services delivered to a patient for an episode of care for a specific condition over a defined period • Payment usually less than sum of FFS parts for that episode • Utilized for care "episodes" with well-defined standards of practice and higher predictability of resource use	Single, global fee paid to providers to manage all care for given patients over a set period of time • Severity adjusted to account for complexity of medical needs • May include additional Care Management payments to support wellness, prevention and "population health management"	Prepayment for services on a per-member-per-month basis, regardless of service volume or cost • Most commonly used for payment to PCPs • Adjusted for gender and age but does not traditionally take into account health status or clinical acuity
Incremental Payment	Pay For Performance (P4P) Financial incentives that reward providers for the achievement of a range of payer objectives, including delivery efficiencies, submission of data and measures to payer, and improved quality and patient safety • Can be in the form of a bonus or withhold structure				

Today's Payment Mechanisms | Evolving Payment Mechanisms

Payment Reform for Outcomes and Quality

Physician Quality Reporting Initiative – Extend payments through fiscal 2014 for the Physician Quality Reporting Initiative, which offers incentives to doctors who report on quality measures to the Medicare Program. It also would expand a feedback program to allow for the development of individual feedback reports for physicians by 2012. Beginning in 2014, if a provider fails to submit quality measures, their Medicare payments would be reduced.

Value-based Purchasing Program – Establish a hospital value-based purchasing program that pay hospitals based on performance on quality measures. (Effective October 1, 2012) Develop plans to implement programs for skilled nursing, home health agencies and ambulatory surgical centers. (Report to Congress January 1, 2011)

Accountable Care Organizations (ACOs) – Allow providers organized as ACOs that voluntarily meet quality thresholds to share in the cost sharing they achieve for the Medicare program. ACOs must agree to be accountable for the overall care of the Medicare beneficiaries, adequate participation of PCPs, promote evidence-based medicine, report on quality and costs, and coordinate care. (Shared savings program established January 1, 2012)

Bundled Payment Pilot – Require the HHS Secretary to establish a national pilot program to develop and evaluate paying a bundled payment for acute , inpatient physician services, physician services, outpatient hospital services and post-acute care services for an episode of care that begins 3 days prior to a hospitalization and spans 30 days following discharge. Establish pilot by Jan. 1, 2013 and expand program by Jan1, 2016, if it is deemed as reducing costs and improving care.

Accountable Care Organizations

- Section 3022 of the Affordable Care Act (ACA) establishes the Medicare Shared Savings Program for Accountable Care Organizations (ACOs) to start January, 2012.
- ***ACO Definition (MedPAC):***
  "a set of providers [which are held] responsible for the health care of a population of Medicare beneficiaries" and accountable for the overall cost and quality of care for the population"
- The primary goals of the Medicare Shared Savings Program are to:
  - Promote provider accountability for a patient population and the coordination of care and services to this population under Medicare parts A and B;
  - Encourage investment in infrastructure and redesigned care processes to drive high quality and efficient service delivery; and
  - Achieve the "Triple Aim" of: (A) better care for individuals; (B) better health for populations; and (C) lower growth in expenditures.
- Qualifying Medicare ACO requirements:
  - Willingness to be accountable for quality, cost, and overall care of Medicare fee-for-service beneficiaries for a minimum of three years
  - Have a formal legal structure to receive and distribute shared savings
  - Have at least 5,000 assigned beneficiaries with sufficient number of primary care ACO professionals
  - Report on quality, cost, and care coordination measures and meet patient-centeredness criteria
- On March 31, 2011, CMS released the Proposed Rule governing ACOs – revised ruling expected this fall

Changes in the Final Rule Released October 20, 2011

- One of the participation tracks allows an ACO to participate in shared savings without downside risk.
- Beneficiaries will be assigned prospectively with retrospective reconciliation.
- Quality measures have been reduced from 65 to 33 with a longer phase in period.
- Once the minimum savings rate has been achieved, all ACO's will receive a share starting with the first dollar.
- There will be expanded opportunities to proactively contact beneficiaries.
- Federally Qualified Health Centers and Rural Health Clinics will be eligible to participate.
- There will be greater flexibility for start dates.
- The frequency of reporting has increased to quarterly.
- 50% participation in an Electronic Health Record (EHR) is no longer a condition of participation.
- Beneficiary assignment will be based only on physician visits, thereby allowing care by other healthcare professionals to be recognized.
- Marketing guidelines have been relaxed so that prior approval is no longer required.

Patient-Centered Medical Homes

PCMH is an approach to providing comprehensive primary care that coordinates with sub-specialists when appropriate. It fosters partnerships between individual patients, and their personal providers, and when appropriate, the patient's family

- Each patient has a **personal physician** who provides first contact, continuous and comprehensive care.
- The personal physician leads a **team** of individuals at the practice level for ongoing care and prevention.
- Care is **coordinated** across medical subspecialties, hospitals, home health agencies and nursing homes, and also with the patient's family and public and private community-based services.
- Care is facilitated by **electronic health records and other information technologies**. Analytic tools allow for patient tracking, clinical monitoring, specialist follow-up, population-based decision making, and predictive modeling.
- **Access** is facilitated by open scheduling as well as expanded and after-hours access to personal physician and practice staff by telephone and through secure e-mail.
- **Targeted financial incentives** reward physicians and providers for supporting medical home features, including additional payments for cost savings and measureable and continuous quality improvement.

Source: NCQA

Delivery and Payment Reform

A fundamental shift in how we deliver and pay for healthcare services

Element of Change	TODAY →	FUTURE
Health Care Focus	Sick Care	Wellness and Prevention
Care Management	Manage utilization and cost within a care setting	Manage on-going health (& Optimize Care Episodes)
Delivery Models	Fragmented / Silos	Care Continuum & Coordination (Right Care, Right Place, Right Time)
Care Setting	In office / hospital / person	Home, e-health, m-health
Physician Platform	Solo practitioners	Multi-specialty, integrated
Clinical Systems/EMR	Transactional	Interoperable, HIE
Quality Measures	Process-focused, Individual	Outcomes-focused, Population based
Reimbursement	Fee-for-service	Value-Based (Outcomes, Utilization, Total Cost)
Financial Incentives	Do more, make more	Perform better, make more
Financial Performance	Margin per service, procedure, etc. (bed, doc, etc.)	Margin per life

Accenture's View of the Market

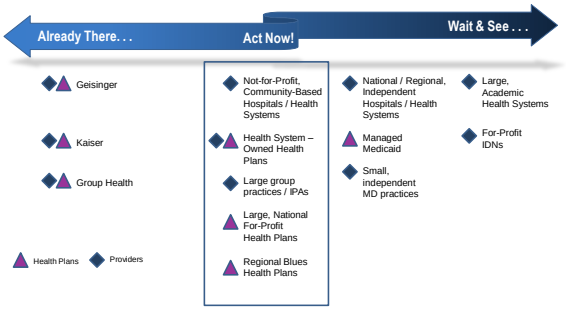
Providers

- ACO development sponsored by hospitals/health systems (but physician led)
  - Largely private community-based health systems
  - Focused decision-making structure
  - Capital capacity to support infrastructure
- Used as physician alignment and growth strategy
- Building capabilities to manage risk
- Becoming insurers (very few)

Payers

- Exploring new business models to provide services to ACO's
  - Claims processing
  - Case/care management
  - Analytics (clinical and actuarial)
- Enhancing the performance of current products
  - Improved quality and cost-effectiveness
- Development of new ACO insurance products (e.g. co-branded with providers
- Developing payer-based delivery systems

Spectrum of Market Activity



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Payer-Provider collaboration has been slow to develop

Challenges

- Historically adversarial payer-provider relationships in some markets
- Harder to innovate when contract negotiations underway / anticipated
  - Traditional contract negotiations still dominate the payer-provider dialogue
- Providers fear greater risk with their dominant payer due to greater financial risk
  - Providers that reduce utilization will see lower revenue from FFS contracts
- As physician employment increases, harder to selectively target them as incentivized decision-makers

Potential Solutions

- Partnerships based on strong payer-provider relationships layered upon contract stability.
- Increased transparency of data
- Lower rates may be offset by payer support for services, infrastructure and capital
- Financial alignment with phased downside risk
- Redefining the relationship and enhancing interdependence
  - New insurance products
  - New care delivery models
  - Highly integrated information systems

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Current Status of ACO's and Payment Reform

1) ***Increasing momentum around Payment & Delivery Reform and ACO formation:***
   - Being driven by Providers and Payers, alike.
   - Extent of activity varies by market/geography and based on the perceived level of competitive threat and/or opportunity; range of "responsiveness" from taking "action now" to adopting a "wait and see" approach.
   - Primary focus for Providers and Payers is **optimizing care delivery to improve clinical outcomes and reduce medical costs.**
   - While CMS' proposed rule for shared savings has significant implications for providers, with many potentially delaying participation in the shared savings program (e.g., beyond January 2012), market leaders are likely to pursue ACOs in the commercial space and "ACO-like" competencies that improve quality and reduce costs.

2) ***For those taking action now, 3 key areas of activity are emerging:***
   - Strategy Development / Validation;
   - Capability Assessment, Design, Development; and
   - Provider-Payer Contracting & Collaboration / Joint Venture Opportunities.

3) ***Key capability needs include:***
   - Provider Network Strategy and Management;
   - Integrated Care Delivery Model;
   - Information Technology / "Connected Health";
   - Information Management and Analytics; and
   - Payment Methodology and Management.

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ACO Core Capabilities. . . A Closer Look

Provider Alignment

- Strengthened Primary Care
- PCP / Specialist collaboration
- Governance
- Organizational Structure
- Network Development & Management
- Contracting
- Financial Strategy & Management
- Clinical Program Management
- Quality Management

Care Delivery

- Episodic Care Management
- Population Health Management
- Prevention & Wellness
- Campaign Management
- Consumer Health Tools
- Clinical Coaching
- Evidenced-Based Protocols
- Care Transition Management

Information Technology

- Interoperability
- EMR, EHR
- Patient Registry
- Longitudinal Health Record
- CPOE
- Clinical Workflow Tools
- Decision Support
- Provider Portal
- HIE
- Claims
- Billing
- Contracting
- Benefits
- Care Management

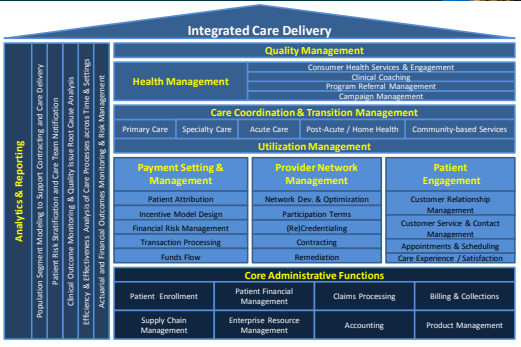
Data Mgmt / Analytics

- Real-time
- Standardized
- Actuarial Analytics
- Condition Risk Stratification
- Patient / Condition Identification
- Clinical Outcomes
- Quality Reporting
- Utilization Reporting
- Cost Reporting
- Budgeting & Forecasting

Payment Setting & Management

- Payment System Strategy
- Payment Setting Approach
- Severity Adjustment Methodology
- Patient Attribution
- Payment Transaction Processing
- Payment Distribution / Funds Flow

Core Capabilities to Support ACO Care Delivery



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Henry Ford Health System

- Henry Ford Health System (HFHS) is a Michigan not-for-profit corporation, founded in 1915
- More than 19,261 full-time equivalent HFHS employees, and more than 23,000 total HFHS employees
- Key Components:
  - Henry Ford Hospital
  - Henry Ford Medical Group (HFMG)
  - Five community hospitals
  - Health Alliance Plan (HAP)
- 3.2 million outpatient visits and more than 88,000 surgical procedures performed at HFHS each year
- More than 99,700 patient admitted to HFHS hospitals

Historical Overview
Business Rationale

- Investment in geographically dispersed community hospitals required the development of a complementary strategy to engage HFMG, HFHS hospital employed and private practice physicians who admit to those facilities:
  - Standardize care based on leading practice
  - Use technology to share clinical data to improve coordination and continuity of care delivery
  - Establish uniform expectations, metrics, targets and thresholds to measure performance
  - Develop common goals and reward structures including incentives earned on the basis of quality.
- Employer Demand for Increased Quality at a Lower cost
  - Beginning with big 3 automaker request for major e-prescribing initiative to cut prescription costs and improve quality
  - Approached by Ford Motor Company
- Complex Compliance Requirements (ARRA/Meaningful Use)
- Changing Payment Systems with Healthcare Reform

Clinical Integration
Program Development Timeline

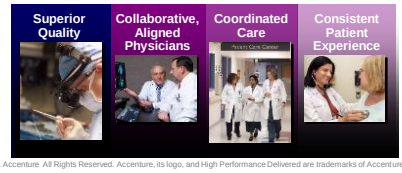
Historical Overview
Strategic Imperative

Vision: Make Henry Ford the system that physicians want to practice in—for its quality leadership in creating an integrated clinical framework with a focus on patients first and an imperative for excellence, collaboration, coordination and clinical value.

Henry Ford Physician Network (HFPN) What is the HFPN?

The Henry Ford Physician Network – a physician driven, clinically integrated network, is in the process of building its core foundation.

- The Network is a physician-led subsidiary of Henry Ford Health System (HFHS), comprised of private practice, HFHS employed and Henry Ford Medical Group physicians, and is focused on delivering even higher quality care and lowering medical costs.
- Quality will be enhanced by measuring performance on physician-defined quality measures, expanding technology into independent practices, and sharing clinical information across the Network with a Health Information Exchange
- Through the Network, and by using the concept of Clinical Integration, physicians will provide optimal value to patients, payers and employers through collaborative best practices, evidence-based medicine and improved efficiency.



Henry Ford Physician Network (HFPN) Clinical Integration is the Foundation of the HFPN

"Clinical Integration is defined as an active and ongoing program to evaluate and modify practice patterns by the network's physician participants and create a high degree of interdependence and cooperation among the physicians to control costs and ensure quality."

Advocate Physician Partners

gripa health care could look like this

Clarian Health

MEMORIAL HERMANN Breakthroughs every day

Henry Ford Physician Network (HFPN) The Clinical Integration Test

An analysis of any physician network's clinical integration program is essentially a three-part test which asks:

1. Whether the network's clinical integration program is **"real"** containing authentic initiatives, actually undertaken by the network, which involve all physicians in the network, and apply to the physicians' practice patterns relative to patients who obtain health benefits under fee-for-service health plans;
2. Whether the initiatives of the program are designed to achieve **likely improvements** in health care quality and efficiency; and
3. Whether joint contracting with fee-for-service health plans is **"reasonably necessary"** to achieve the efficiencies of the clinical integration program

Henry Ford Physician Network (HFPN)
Clinical Integration Core Tenets

The Henry Ford Physician Network is an active and ongoing program developed to evaluate and modify practice patterns of our physician participants and create a high degree of interdependence and cooperation among it's physicians to control costs and ensure quality.

Enhanced Accountability
- Quality measures / benchmarking to set performance expectations
- Peer-to-peer, physician-directed counseling
- Remediation activities to ensure accountability

Dissemination of Best Practice
- Provide the forum, continuing medical education, and process support to assure that leading practice is communicated in a timely and efficient manner and consequently adopted into standard practice

Performance Measurement
- **Quality measures used across the network**
- **Benchmarking based on leading practices**
- **Performance expectations linked to reward structures**

Practice Support / Tools

- Access to systems, resources, and services to support practices in program implementation

Improved Care Coordination
- Improved communication and processes among providers of care including primary, specialty, and ancillary care

Patient Engagement Tools
- Health assessments, patient and provider messaging, health information, and health coaching

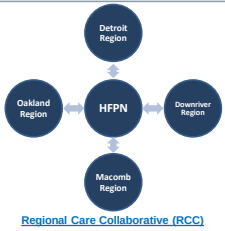
Physician Performance
Physician Member Requirements

- Each physician will have at least 5 meaningful specialty specific metrics to be measured against for performance
- Physicians will comply with the established process for providing clinical data
- Physicians will participate in metric reviews through regional clinical management forums
- Physicians will participate in required training around the quality metric process and performance targets

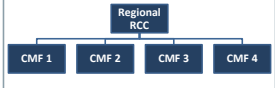
Measures by Category

	Medical Specialties																						Surgical Specialties											
	TOTAL	ENT	Pediatrics	Allergy/Immunology	Psychiatry/Behavioral Health	Cardiology	Clinical Care/Internal	Dermatology	Emergency Medicine	Endocrinology	Gastroenterology	Hospitalist	Infectious Disease	Neurology	Oncology	Pain Management	Pathology	Pulmonology	Rheumatology	Radiology	Anesthesiology	Cardiovascular Surgery	General Surgery	Neurosurgery	OB/GYN	Ophthalmology	Orthopedic Surgery	Otolaryngology	Plastic Surgery	Urology	Vascular Surgery
Utilization/Efficiency	7	4	3	1	2	3	0	0	3	2	1	3	1	3	4	2	4	0	3	0	4	0	3	4	1	2	3	3	2	2	3
Quality Processes	77	13	11	8	5	7	8	7	8	6	10	10	11	5	8	6	6	2	9	3	7	5	16	11	6	14	6	12	8	6	8	12
Administrative	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
Patient Satisfaction	1	0	0	0	0	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Clinical Outcomes	16	5	1	1	0	3	2	0	0	3	0	0	0	3	0	0	0	1	0	0	0	1	1	2	4	1	2	1	1	1	1	1
Total	104	25	18	13	10	16	13	10	15	14	14	17	15	14	15	11	13	5	16	6	14	8	23	18	15	22	12	20	15	12	14	19

Henry Ford Physician Network (HFPN)
Functional Structure



Regional Care Collaborative (RCC)
- Coordinated by a RCC Medical director responsible for Implementing HFPN initiatives locally
- Administer / Manage Clinical Management Forums
- Aggregate to impact quality, efficiency, and costs through dialogues with other HFPN physicians in that region
- Collaborate with local leaders on local initiatives
- Peer review and remediation



Clinical Management Forums
- Promote collaboration between HFPN physicians
- Promote and disseminate best practices to HFPN members
- Provide appropriate clinical outlier case review
- Execution forum for utilization management programs

Henry Ford Physician Network (HFPN) Board of Trustees

HENRY FORD PHYSICIAN NETWORK BOARD OF TRUSTEES

	APPOINTED TRUSTEES: (1/2 Appointed HFMG Trustees, 1/2 Appointed Non-HFMG Trustees).		EX-OFFICIO TRUSTEES: Serve by virtue of indicated office.
	APPOINTED HFMG TRUSTEES	APPOINTED NON-HFMG TRUSTEES	
2011	5	5	HFHS Chief Financial Officer HFMG Chief Executive Officer HFHS Physician Trustee (Private Practice) HFPN President and CEO (Interim) HFHS President and CEO Designee
2012	6	6	HFHS Chief Financial Officer HFMG Chief Executive Officer HFHS Physician Trustee (Private Practice) HFPN President and CEO (Interim) HFHS President and CEO Designee

Henry Ford Physician Network (HFPN) Challenges for HFPN

- Clinical Integration
  - Journey from FTC-validated Clinical Integration to "true" Clinical Integration
  - Practice orientation and engagement surrounding collection of data and spread of best practice
  - How does the organized Medical Staff advance more accountable care?
    - How do avoidable admissions and preventable readmissions enter into performance review?
    - Adherence to evidence-based protocols?
  - How do we engage post-acute care providers?
    - PCP's, SNF, LTC, Home Health, OP Phys Therapy, etc.

Henry Ford Physician Network (HFPN) Directions for 2012

- Metric Measurement
- Clinical Connectivity
- Contracting – all at evaluation/appropriateness/planning levels
  - Collaborative with HAP: Regarding our HFHS self-insured programs and other offerings in the market
  - Other employer groups
  - Federal Health Care Reform opportunities
    - Shared Savings
    - Pioneer ACO
    - Bundled Payments
    - Patient-Centered Medical Homes

HFPN's perspective on Ambulatory Surgery Centers

- Open to including, while not yet having the opportunity
- Would require consensus on minimum certification and quality standards
- Would require physician participation in clinical integration metric program that includes quality and utilization measures

Impact of Payment Reform and ACO's on Ambulatory Surgery Centers

- Lower cost narrow network products are emerging in the market.
- ASC's will be downstream providers to those who manage overall patient care AND financial risk.
- Integration with EMR's and quality reporting systems will be essential, either directly or through health information exchanges (HIE's).
- Key unknowns:
  - Will sponsoring health systems insist on keeping patients in system?
  - Will the value proposition of quality and cost result in patient steerage toward ASC's in the new healthcare economy?
- And… what can you do to impact those unknowns???

Strategic Considerations: Reducing Risk and Prove Value

- Stay close to emerging decision makers
  - Health system leaders
  - PCP's and Patient Centered Medical Homes
- Consider alignment strategies
  - Is there an early mover advantage?
- Ensure that you are delivering value and build infrastructure to demonstrate that value
  - Quality and outcomes AND cost-effectiveness
- Manage the perception that ASC value is overestimated due to clinical and payer mix