HFMA Texas State Chapter

Value-Based Reimbursement

The Movement From Volume to Value: What Is the End State, and How Do We Get There?

March 18, 2014
Agenda and Objectives

Agenda

I. Industry Trends
II. Payment Reform
III. Clinical Integration
IV. Key Takeaways

Objectives

• Review key factors impacting the current healthcare environment across the nation.

• Describe key payment reform initiatives that support the transition from a volume-based to a value-based reimbursement environment.

• Consider the pacing of the movement to value-based care as it relates to the financial, operational, and strategic implications on provider organizations.

• Review examples of what other provider and payor organizations are doing to move to value-based care and greater clinical integration.
I. Industry Trends
I. Industry Trends  
*Runaway Healthcare Costs*

**Features of Our System**

- Reimbursement that rewards volume above all else.
- Separation between the *financing* and *delivery* of healthcare.
- Highly fragmented markets consisting of largely independent players.

**Result**

- Little consensus regarding what constitutes quality and how to improve outcomes.
- Medical “arms race.”
- Out-of-control costs.
- Little to show for expenditures in terms of population health management outcomes.

*The economics of fee-for-service (FFS) medicine have resulted in an accelerated growth in healthcare costs.*

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*Growth in Total Health Expenditure Per Capita, U.S. and Selected Countries, 1970-2008*
I. Industry Trends

Healthcare Reform

The healthcare landscape will continue to change rapidly as key initiatives from the Patient Protection and Affordable Care Act (PPACA) take shape and evolve over time.

Access
- Health exchanges.
- Expansion of Medicaid coverage.
- Medicare/Medicaid dual eligibles.
- Network development.

Cost
- Innovative payment delivery models focusing on value, not volume.
- Bundled payments.

Quality
- Innovative care delivery models.
- Improved population management.
- Emphasis on prevention and wellness.
- Integration, accountability, and risk sharing.

One of the greatest challenges that organizations face is determining how to move from volume to value in a financially responsible manner.
I. Industry Trends
Clinical Continuum

Healthcare organizations will have to collaborate to succeed in a patient-centric, value-based system. By working together to develop best practices and standardized ways of practicing medicine, patient care can subsequently be improved.

The movement to value-based care entails a shift from the previously fragmented and inefficient healthcare system to a focus on the patient’s total health picture.
I. Industry Trends
Shifting Risk in the Payment System

As reimbursement moves from payments based on an FFS methodology (volume) to a more value-based system (quality), risk will also shift from payors to providers.

The Risk Continuum Associated With Existing and Proposed Reimbursement Structures

- FFS
- Medical Home
- Bundled Payment
- Payment for Episodes of Care
- Global Payment With Performance Risk and P4P
- Global Payment With Financial Risk

- Consumers
- Employers
- Health Plans
- Government Payors
- Physicians
- Medical Groups
- Hospitals
- Other Providers

2 Medical homes that receive extra dollars for patient management.

An emphasis on risk-based models will hold providers accountable for the total health of members.
To prepare for the additional risk providers will face, key considerations must be addressed in advance of the transition to value-based arrangements.

- The elimination of cost from the system.
- The potential change in payor mix.
- Necessary measurement reporting and increased transparency.
- Collaboration based on strong provider partnerships.
- Core insurance/risk competencies (internal, through partnerships/relationships).
II. Payment Reform
More than ever before, it is increasingly important for an organization to review, evaluate, and monitor the managed care contract portfolio, as managed care continues to be a key driver of the organization’s overall financial performance.
II. Payment Reform

Managed Care Strategy Considerations

• How do you grow the commercial business?
• What new products are the health plans interested in developing or marketing?
• What is your plan with health exchanges?
• Are you anticipating additional Medicaid volume with the Affordable Care Act?
• Should you be considering new payment methodologies that are value rather than volume based?
• Would expanding your Medicare Advantage contracts improve your market share, contribution margins, and profitability?
• Are your commercial payor rates similar, within a narrow pricing band?
• Do you have a parity contracting strategy with all your commercial and Medicare Advantage payors?
• With clinical integration, will the payors recognize the value you are providing to their members?
Providers are contemplating five primary contracting avenues as they move toward value-based care.

<table>
<thead>
<tr>
<th>Commercial</th>
<th>Medicare</th>
<th>Medicaid</th>
<th>Insurance Exchanges</th>
<th>Employee Health Plans</th>
</tr>
</thead>
</table>
| • Shared to full risk.  
• Common measurement and participation in pay-for-performance (P4P) program.  
• Medical home.  
• Thin capitation.  
• Narrow network. | • Narrow network for Medicare Advantage (MA).  
• Shared to full risk for MA.  
• CMS/CMMI pilot programs.  
• Medicare Shared Savings Program (MSSP).  
• Specific programs for dual eligibles. | • Medical home.  
• Innovative models for specialized Medicaid patient populations.  
• Specific programs for dual eligibles.  
• Shared risk. | • Narrow network.  
• Shared risk (need to understand population).  
• Common medical management. | • Benefit design.  
• Network tiers.  
• Common clinical protocols.  
• Common medical management.  
• Programs for high-risk members.  
• Wellness. |

Organizations with high government payor populations are starting with Medicare and Medicaid initiatives.
II. Payment Reform
Product Focus (continued)

The economic reality of reform has caused enormous changes in the insurance industry; plans are differentiating themselves through the creation of innovative products.

Strategies utilized within and across the different contracting vehicles will have varying effects on provider reimbursement.
II. Payment Reform

Commercial Payor Initiatives – Examples

Recent commercial payor trends have focused on mitigating provider increases, positioning providers to better manage the health of a population, and testing innovative payment approaches, including value-based methodologies.

<table>
<thead>
<tr>
<th>Payor</th>
<th>Value-Based Methodologies</th>
<th>Incentive Measures/Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Plan 1</td>
<td>Risk-Based Models and Total Cost of Care</td>
<td>Accountable care models with large health systems to manage care delivery and outcomes of targeted populations.</td>
</tr>
<tr>
<td>Health Plan 2</td>
<td>P4P</td>
<td>Hospital and physician quality incentive programs.</td>
</tr>
<tr>
<td>Health Plan 3</td>
<td>PCMH</td>
<td>Support of PCPs in their effort to manage individual risk and produce better outcomes.</td>
</tr>
<tr>
<td>Health Plan 4</td>
<td>P4P</td>
<td>Achievement of improved health outcomes and the reduction of costs through quality, affordability, and patient satisfaction initiatives.</td>
</tr>
<tr>
<td></td>
<td>Reporting</td>
<td>Physician performance reporting.</td>
</tr>
<tr>
<td>Health Plan 5</td>
<td>P4P</td>
<td>Payment increases directly linked to quality performance.</td>
</tr>
<tr>
<td></td>
<td>Bundled Payments With Oncologists</td>
<td>Identification of best practices and improvement of patient outcomes through a reduction in treatment variation.</td>
</tr>
<tr>
<td></td>
<td>PCMH</td>
<td>Direct partnerships with employers to closely manage population health.</td>
</tr>
</tbody>
</table>
II. Payment Reform  
Example - BCBSMA AQC

*Massachusetts launched the AQC in January 2009, which combines a per patient global budget rate with quality performance incentives of up to 10%.*

<table>
<thead>
<tr>
<th>Five Key Cornerstones of the Model</th>
<th>Improvements Compared to Prior “Capitation”</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. <strong>Global Budget Plus P4P</strong> – Fixed payment using baseline historical costs per member <em>plus</em> variable quality payment based on nationally accepted measures.</td>
<td>• AQC is appropriately funded because the global rate is based on historical patient care, is severity-adjusted, and should not disincentivize physicians from providing care.</td>
</tr>
<tr>
<td>2. <strong>Performance Measures</strong> – Focus on safe, timely, effective, and patient-centered care. Includes 32 ambulatory measures, 32 hospital measures, and 16 unexplained practice variations.</td>
<td>• Pairing the global payment with quality metrics holds providers accountable for delivery and outcomes.</td>
</tr>
<tr>
<td>3. <strong>Sustained Partnership</strong> – A 5-year contract term between BCBSMA and providers (PCPs, specialists, and hospitals).</td>
<td>• The annual severity adjustment ensures that physicians do not avoid sick patients.</td>
</tr>
<tr>
<td>4. <strong>CI</strong> – PCP-led continuum of care.</td>
<td>• This includes a range of risk-sharing and stop-loss provisions.</td>
</tr>
<tr>
<td>5. <strong>Savings</strong> – Reduction in duplicative services, use of more cost-effective options, and elimination of preventable costs, such as readmissions.</td>
<td>• The model applies an annual inflation factor from the CPI to the global budget.</td>
</tr>
</tbody>
</table>

*Upside risk (potential savings) equaling downside risk (potential losses) is the program’s goal in order to incentivize providers to eliminate waste.*
PCMH payment models typically incorporate a PMPM care management payment with a shared savings opportunity for providers.

Current State

- Physicians see their own patients and supervise residents.
- Much of the work is being completed and coordinated by the physicians.
- Nurse practitioners (NPs) have their own panel of patients.
- There is potential to expand the nurse role.
- More medical assistants are needed.
- There is a need to integrate APCs into the model.
- No designated care coordinators/patient navigators, case managers, or social workers are present.
- There is an opportunity to empower staff to work at the “top of their license.”
- Job descriptions should be redesigned.
- Pod approaches are not utilized.
II. Payment Reform
Bundled Payments

The bundle supplies a single payment, encompassing services provided as part of a condition or episode of care.

Bundled Payment Environment
Single Payment for All Services

Payor

$ + Risk

Surgeons
Other Physicians
Post-Acute Services

Hospital Services
Hospital Readmissions
Post-Acute Physicians

Three Main Considerations for “Packing” a Bundle

• What cases or conditions will the bundle be for?
• How long will the bundle be valid/what service period pre- or post-admission will it cover?
• What types of services should be included or excluded from the bundle?

The payor and providers can choose what services to pack in the bundle, how long the bundle covers pre- and post-episode (e.g., 30 days, 60 days, 90 days), and any specific patients included or excluded from the bundle.
II. Payment Reform
Medicare Sustainable Growth Rate

The use of sustainable growth rate (SGR) targets was intended to control the growth in aggregate Medicare expenditures for physicians’ services.

The Balanced Budget Act of 1997 specifies the formula for establishing SGR targets for physicians’ services under Medicare.

Due to unexpected growth in the 2000s, the SGR began to produce cuts in payment rates that exceeded expectations, forcing Congress to overturn the cuts each year.

- In 2014, the SGR could cause an estimated 24% payment cut to Medicare physician rates as of January 1, 2014.
- A short-term patch was created that has prevented physicians from seeing payment cuts for the first 3 months of 2014.

It is estimated that a permanent fix for the SGR’s shortcomings could now cost between $139 billion and $175 billion, after years of avoiding needed reform.

Suggested permanent SGR reform for Medicare’s physician payments advocates further movement from an FFS model to a value-based arrangement, although this change comes with a high cost.
II. Payment Reform  
Value-Based Performance Payment Program

In a major step toward consolidating quality measures and incentives, current P4P programs will be combined into a single value-based performance (VBP) payment program starting in 2017.

VBP Payment Program

- **Physician Quality Reporting System**
  - Physicians receive small increases in their payment rates for reporting on quality.

- **Meaningful Use**
  - Physicians receive small increases in rates for meeting standards for the adoption of health information technology (IT).

- **Value-Based Modifier**
  - Medicare is scheduled to phase in a modifier that will adjust payment rates based on measures of the quality and efficiency of care.

Consolidating the three existing quality programs into a single VBP payment program will substantially increase the impact of the programs.
II. Payment Reform

Physician Quality Reporting System

The Physician Quality Reporting System (PQRS) has been using incentive payments, and will begin to use payment adjustments in 2015, to encourage eligible professionals (EPs) to report on specific quality measures.

- The program provides an incentive payment to EPs who satisfactorily report data on quality measures for covered Physician Fee Schedule (PFS) services furnished to Medicare Part B FFS beneficiaries.

- EPs choose at least three individual measures or one measures group as an option to report on measures to CMS.
  - By reporting PQRS quality measures, providers also can quantify how often they are meeting a particular quality metric.
  - With the feedback report provided by CMS, EPs can compare their performance on a given measure with their peers.

- EPs should consider the following factors when selecting measures for reporting:
  - Clinical conditions commonly treated.
  - Types of care delivered frequently (e.g., preventive, chronic, acute).
  - Settings where care is often delivered (e.g., office, emergency department [ED], surgical suite).
  - Quality improvement goals for 2013.

- EPs may choose to report quality information through varying methods, including Medicare Part B claims, qualified PQRS registry, qualified electronic health record (EHR) product, or a PQRS EHR data submission vendor.

Financial Impact of PQRS

- 0.5% 2013
- 0.5% 2014
- 1.5% 2015 and After
II. Payment Reform
Value-Based Modifier

CMS will phase in the application of a value-based modifier (VBM) for physician services in 2015.

- The program uses existing PQRS and EHR meaningful use measures, along with select total per capita cost metrics, to measure physician performance.
- There are a total of 62 preliminary measures for the VBM program.
- The application of the modifier will start in 2015 for groups of physicians with 100 or more EPs. All physicians and physician groups will be subject to the VBM in 2017.

Calculation of the VBM Using Quality Tiering Approach

<table>
<thead>
<tr>
<th>Quality/Cost</th>
<th>Low Cost</th>
<th>Average Cost</th>
<th>High Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Quality</td>
<td>+2.0X%(^1)</td>
<td>+1.0X%(^1)</td>
<td>0.00%</td>
</tr>
<tr>
<td>Medium Quality</td>
<td>+1.0X%(^1)</td>
<td>0.00%</td>
<td>-0.50%</td>
</tr>
<tr>
<td>Low Quality</td>
<td>0.00%</td>
<td>-0.50%</td>
<td>-1.00%</td>
</tr>
</tbody>
</table>


\(^1\) X is undefined because the program must be budget-neutral and therefore will depend on the total sum of negative adjustments in a given year.

Reimbursement is being increasingly tied to value, even for Medicare FFS payments.
## II. Payment Reform

### Performance Measures

#### Hospital Quality and Safety Examples

- **Clinical process measures.**
  - Acute myocardial infarction (AMI).
  - Heart failure care.
  - Pneumonia care.
  - Surgical care.
- **Clinical outcome measures.**
  - Hospital-acquired infections.
  - Complications after major surgery (AMI, PE/DVT, pneumonia).
  - Obstetric trauma.
- **Patient care experiences.**
  - Communication quality: physicians.
  - Communication quality: nurses.
  - Responsiveness.
  - Discharge support/planning.
- **Developmental measures.**

#### Ambulatory Care Quality Examples

- **Clinical process measures.**
  - Depression.
  - Diabetes.
  - Cardiovascular disease.
  - Cancer screening.
  - Pediatric: appropriate testing/treatment.
  - Pediatric: well-child visits.
- **Clinical outcome measures (triple-weighted).**
  - Diabetes (HbA1c, LDL-c control, and blood pressure control).
  - Hypertension (blood pressure control).
  - Cardiovascular disease (blood pressure control, LDL-c control).
- **Patient care experiences.**
  - Quality of clinical interactions.
  - Integration of care.
  - Access to care.
- **Developmental measures.**
II. Payment Reform

Narrow Networks

Payor-driven narrow networks have been in the market for some time. Payors will continue to develop narrow networks in order to reduce premiums to employers and increase market share.

• There are multiple considerations for a hospital to participate in a payor-driven narrow network.
  – Is the volume new, existing, or a combination of both?
  – Payors expect lower rates of reimbursement in return for volume.
  – Is the volume realistic?
  – With an increase in volume, will the increase in volume offset the revenue drop?
  – Do the net contribution margin and net profit dollars increase?
• Payors are using two terms simultaneously in the market: “narrow network” and “health exchange.”
  – Payors are attempting to move traditional commercial volume to a narrow network/health exchange network with lower reimbursement to providers.
III. Clinical Integration
III. Clinical Integration
Strategic Impetus to Integrate

Clinical Integration – A Symbiotic Relationship
Clinical integration helps establish a common vision and purpose among providers to deliver safe, efficient, timely, and patient-centered care.

Clinical Integration – Promoting Care Coordination
Clinical integration is needed to facilitate the coordination of patient care across conditions, providers, settings, and time in order to achieve care that is safe, timely, effective, efficient, equitable, and patient-focused. To achieve clinical integration, we need to promote changes in provider culture, redesign payment methods and incentives, and modernize federal laws.1

- National mandates for patient safety, quality of care, and price transparency are difficult to meet without physician/hospital collaboration.
- Clinical integration involves improving patient care quality and eliminating inefficiencies within the continuum of care.
- Hospitals need physicians to meet quality targets to earn incentives or reduce undesired outcomes to avoid payment penalties.
- Hospitals and physicians need each other to improve quality across the continuum of care.

1 Source: www.aha.org/advocacy-issues/clininteg/index.shtml.


"Physicians need hospitals; hospitals need physicians. And, most of all, patients need providers to work together."2 – Denis Cortese, M.D., CEO of the Mayo Clinic
The end-state model is a clinically integrated network (CIN) of providers who follow common clinical protocols, have aligned measures and incentives based on improved value, and obtain joint payor contracts.
## III. Clinical Integration

**The Spectrum of Integration**

<table>
<thead>
<tr>
<th>Independent/Competitive</th>
<th>Segmented Integration</th>
<th>Clinical Integration</th>
<th>Accountable Care Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Traditional medical staff/hospital relationship.</td>
<td>• Organizational models created to achieve physician/hospital integration (e.g., joint ventures, employment).</td>
<td>• Systems and processes in place to measure quality and cost across a continuum (e.g., hospital, physicians, pharmacy, outpatient services).</td>
<td>• All characteristics of clinical integration, with a greater degree of financial integration and interdependence.</td>
</tr>
<tr>
<td>• Physicians are “customers” of the hospital.</td>
<td>• Physician-only models may include entering into managed care risk (e.g., IPA).</td>
<td>• Selective participation of physicians who are willing to comply with a set of protocols and outcome measures.</td>
<td>• Ability to approach the market and payors with an integrated system (i.e., hospitals, physicians, and other providers of care).</td>
</tr>
<tr>
<td>• Competition over outpatient services and revenue streams.</td>
<td>• The focus is on creating structures that align strategic and financial goals – typically of one aspect (or segment) of the healthcare delivery system (e.g., service line, outpatient service, physician recruitment, payor type).</td>
<td>• Pursues new models of clinical care delivery to enhance the management of chronic disease and coordination of care overall.</td>
<td>• The culture is totally focused on the success of the system versus individual components (e.g., hospital versus physician group).</td>
</tr>
<tr>
<td>• FFS mechanisms predominate.</td>
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</table>
III. Clinical Integration

Transitioning From FFS to Value

The formation and development of a CIN can be segmented into five domains.

 Governance and Organizational Structure
- Determining the appropriate legal structure.
- Developing membership criteria and levels (e.g., owner, affiliate) for the clinically integrated entity.
- Developing input and decision-making structures, especially if the entity includes members from within and outside of the organization.

 Clinical Leadership and Integration
- Analyzing disease registry, employee health, and claims data to determine clinical focus areas.
- Outlining and prioritizing clinical care improvements.
- Overseeing clinical development teams to address variation and create tools for improvement.
- Developing a framework for physician leadership, management, and accountability for protocol implementation.

 Payor Contracting
- Developing a value-based reimbursement philosophy that aligns with the clinical goals.
- Creating a payment methodology that standardizes the approach to reimbursement across payors.
- Establishing relationships with payors to facilitate the movement toward value.

 Funds Flow and Incentive Design
- Determining how dollars will flow to component organizations or within the organization.
- Developing capitation and other value-based payment models.
- Updating physician compensation structures to align with new methods of reimbursement.

 IT and Analytics
- Developing reports of clinical and financial performance that reflect the priorities of value-based care.
- Incorporating tools that provide clinical decision support and identify gaps in care.
- Identifying the most efficient/effective methods for data exchange across all participants.
As networks form, not all providers are positioned to be at the core (e.g., accountable care organization [ACO], CIN), so many are assessing where they fit into a broader network of like-minded partners.

**Provider Network Tiers**

**Contractors**
- No governance or decision-making participation.
- FFS only.
- For example, radiology group.

**Participants**
- No governance or decision-making participation.
- FFS with shared savings.
- For example, home health agency.

**Affiliates**
- Participation in decision making.
- Potential risk sharing.
- For example, aligned independent medical group.

**Core**
- Ownership (if necessary).
- Governance.
- Risk sharing.
- Surplus sharing.
### III. Clinical Integration

#### Payor Contracting

<table>
<thead>
<tr>
<th>Less Integrated</th>
<th>Range of Business Relationships</th>
<th>More Integrated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent Contracting Decisions</td>
<td>Potential Models of Integration</td>
<td>Potential Models of Integration</td>
</tr>
<tr>
<td><strong>“Messenger” Model</strong></td>
<td><strong>Pay for Performance</strong></td>
<td><strong>Risk Sharing</strong></td>
</tr>
<tr>
<td><strong>Third-Party Messenger</strong></td>
<td><strong>Physician/Hospital Alignment</strong></td>
<td><strong>“United Front”</strong></td>
</tr>
</tbody>
</table>

#### Independent Contracting Decisions
- This model involves separate, independent, and unilateral contracting decisions.
- Offers and counteroffers between individual physicians and payors are conveyed by PHO messenger.
- Objective information is communicated to providers regarding proposed contract terms.

#### Pay for Performance
- Care is provided in accordance with quality targets.
- The quality of care is reviewed and monitored.
- There are provisions for adequate peer review if quality targets are not achieved.
- Payments are based on historical activity to avoid referral incentives.

#### Risk Sharing
- Providers share the responsibility for cost or utilization and have a significant positive gain for achieving targets.
- Members or owners share financial risk directly or through membership in another organization.

#### Clinical Integration
- Patient-centered care focused on common understanding of desired outcomes.
- Multispecialty network of providers.
- Integrated IT and efficient information exchange.
- Compliance with UM and performance standards.

#### Financial Integration
- System-wide efficiencies across providers.
- Centralized ownership.
The pacing of clinical and financial integration activities is paramount. Achieving clinical integration without financial integration will leave providers in a situation in which they are not able to share in the savings generated by driving utilization out of the system.

A network of providers who coordinate in the care delivery and management processes under a set of aligned performance incentives.

A financial function that expands providers’ ability to manage risk and innovate payment systems that allow them to better leverage the CIN.

The goal of successfully achieving both clinical and financial integration is to be able to actively manage and improve the health of a given population.
### III. Clinical Integration

#### Example #1 – Nonurban Hospital With Local Providers

**Background**
- This hospital has 250 beds and is 40 miles outside of a major metropolitan city.
- The core market represents a geographic niche with viable demographics.
- Inpatient market share in the core market is high.
- The payor market is consolidated, and one plan is dominant.
- The medical community is predominantly composed of small, independent, single-specialty physician practices.
- A significant proportion of the primary care base, while generally loyal to the hospital, is economically aligned with a regional network of primary care practices.
- Relationships with physicians, most of whom are very loyal to the hospital, are strong.
- The hospital is preferred by affiliated physicians and patients.
- Multiple clinical affiliations augment local expertise.
- Quality, excellence, and continuous improvement are areas of ongoing emphasis for the organization.
- Costs and utilization are lower compared to other area hospitals.
- The hospital has limited experience with pilots for care management of specific patient populations.

**Considerations for the Future**
- Most of the covered lives cared for by the hospital and the medical community are “owned” by the regional primary care network.
- Market share of covered lives will be a key measure of indispensability in the future, replacing today’s emphasis on market share of beds, discharges, and/or specialists.
- Local PCPs have growing expertise to support the management of care for specific populations.
- Most nearby competitors have achieved greater economic alignment with physicians and have a larger base of employed PCPs.
- Hospital-centric mind-set means the health system model is underdeveloped.
- Despite pilot initiatives around care coordination, the care model remains fragmented, with generally uncoordinated care transitions.
- Success in new care delivery models and under new payments models will require more than improved performance on traditional metrics.
- The financial capacity to fund growth is limited.
III. Clinical Integration

Example #1 – Nonurban Hospital With Local Providers (continued)

The key to the hospital’s future is to strengthen existing relationships and establish new ones that add value, capture new markets, and accelerate the development of new competencies and capabilities.

Secure an economically aligned referral base in order to be indispensable in the primary market.

Build the competencies required to be successful as healthcare reform drives delivery and payment system changes.

Enhance financial strength and market position to continue to operate as an independent hospital/health system.

Develop a system of community care that is no longer hospital-centric, reaches out proactively, and engages all providers.

Shift focus from managing episodes of hospital-based care to managing the health of a population, thereby requiring clinical integration.
The hospital’s previous investments in cultivating strong physician relationships, implementing technology, and engaging in continuous improvement provide a strong foundation for the medical community to build upon.

- Continuous quality improvement initiatives.
- Strong physician/hospital relationships and shared decision making.
- Platform for exchanging electronic health data.
- PHO.
- Bundled payment initiatives.
- Population health management tools and delivery of targeted, cost-effective care.
- Infrastructure that encourages and facilitates collaboration.
- Culture that supports physicians in delivering the best care.

- Transforming the delivery system.
  - Economic alignment between PCPs and specialists.
  - Improve geographic access to primary care.
  - Development of a health system model with stronger linkages across system of care.
- Managing a population.
  - Evidence-based protocols and care guidelines.
  - Coordinated care transitions engaging medical staff, other providers, and community organizations.
  - Decision support tools and reporting capabilities.
  - Maintenance of cost discipline.
- Leveraging relationships.
  - New affiliations and partnerships with providers as well as with payors.
  - Capitalizing on existing expertise.

• Example #1 – Nonurban Hospital With Local Providers (continued)
More than a dozen inpatient facilities and over 1,000 employed physicians formed a CIN focused on improving the quality and efficiency of care being delivered. The CIN members will collaborate and innovate to:

- Improve Outcomes
- Gain Efficiencies
- Deliver Value to the Populations We Serve

Guiding Principles

- Support Local Autonomy and Independence
- Collaborate With Independent Providers Who Choose to Work Together
- Provide Options for Degree of Involvement
- Engage Physicians
- Focus on Innovating to Create Value for Purchasers and Patients
Two main functional areas have been identified to provide benefit to members of the CIN: (1) payor contracting and (2) shared services.

<table>
<thead>
<tr>
<th>Payor Contracting</th>
<th>Shared Services</th>
</tr>
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<tbody>
<tr>
<td>• Integrated IT.</td>
<td>• Vendor contracts and pricing.</td>
</tr>
<tr>
<td>– Health information exchange.</td>
<td>– Supply chain.</td>
</tr>
<tr>
<td>– Disease registries.</td>
<td>– Consulting.</td>
</tr>
<tr>
<td>• Utilization, medical management, and care design.</td>
<td>• Provider credentialing.</td>
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<tr>
<td>– Utilization review.</td>
<td>• Best practices and education.</td>
</tr>
<tr>
<td>– Standard protocol development and compliance.</td>
<td>– Evidence-based practice guidelines.</td>
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<tr>
<td>– PCMH.</td>
<td>– Quality improvement.</td>
</tr>
<tr>
<td>– Standardized care transitions.</td>
<td>– Staff “in-services.”</td>
</tr>
<tr>
<td>– Care management and infrastructure.</td>
<td>– Industry trends.</td>
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<td>• Contracting.</td>
<td>– Regulatory compliance.</td>
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<td>– Collective negotiations.</td>
<td>• Medical delivery support.</td>
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<td>– Network formation and contract execution.</td>
<td>– Physician staffing/rotations.</td>
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<td>– Funds flow design and planning.</td>
<td>– Medical transport.</td>
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<td>• Managed care administration</td>
<td>• Centralized corporate/other functions.</td>
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<tr>
<td>– Risk management support.</td>
<td>– Human resources (HR)/benefits.</td>
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<tr>
<td>– Data analytics and reporting.</td>
<td>– Revenue cycle.</td>
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<td>– Surplus and deficit accounting and distribution.</td>
<td>– IT.</td>
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<td>– Pharmacy.</td>
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The ultimate goal is to evolve the CIN through the management of a series of phased-in populations.

- The CIN will start with consistent measurements and the development/refinement of programs for major chronic conditions, using the EHP as a starting point.
- The CIN will evaluate payor contracting opportunities to expand population management capabilities to additional patient populations.
- As a first step in this process, it will evaluate MA.

A single EHP network will be developed by year-end 2014 aimed at improving the health of employees through clinical integration and reducing the total cost of care.
IV. Key Takeaways
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Strategic Trends

• **Payor-Driven Payment Changes** – Payors are establishing ACOs, shared savings plans, bundled payments, etc. This trend will continue and accelerate.

• **Investment in Clinical Integration** – More progressive health plans view clinical integration as a benefit for reducing LOS, managing patient populations, and improving quality.

• **Return of Risk Contracts** – Risk contracts include an emphasis on capitation with providers and the establishment of risk pools.

• **Employer-/Payor-Driven Narrow Networks** – Narrow networks often involve large employers contracting directly with large health systems and provider networks.

• **Increase in Medicaid Population** – The expansion of Medicaid may result in the introduction of new payors in the market.

• **Health Exchanges** – As the marketplace matures and more information becomes available about the demographics and utilization patterns of the exchange members, health plan strategies will also evolve accordingly.

*New payment methods and delivery models, such as ACOs, medical homes, shared savings plans, bundled payments, and risk sharing, need to be established and evaluated carefully.*
IV. Key Takeaways

• The burning platform is here.
  – This situation is evidenced by significant federal, state, and commercial payor initiatives; their strategic direction; and their financial urgency (governmental).
  – Health systems are focused on eliminating waste from the system.
  – Strong physician partnerships (with the right physicians) are critical to driving change and protecting short-, medium-, and long-term market share.
  – Systems focused on efficiencies must restructure contracts to receive payment for improved value.

• The pacing of the movement to value-based care is critical.
  – Providers remain largely dependent on a productivity-based system and cannot simply “flip a switch.”
  – As utilization is taken out of the system (through more focused medical/chronic disease/population health management initiatives), hospital and specialist financial performance will be at risk if contracts are not restructured.

• Not all organizations can or should strive for the end-state model (in its totality).
  – It is critical (no matter what the provider type) to focus on efficiencies, measurement, and quality.
  – It is also essential to execute a strategy that closely aligns the organization with preferred care partners.
Questions & Answers

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