Accountable Care Organizations: From Promise to Progress

April 24, 2013

We strongly encourage you join the call by receiving a call-back.

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California HealthCare Foundation

California Improvement Network

Better Ideas for Chronic Disease Care

Today's Speakers

Brian Hodgkins, PharmD
Executive Vice President, Heritage ACO

Karen Driskill, RN
Vice President, Heritage Provider Network
Vice President, Heritage ACO

California Improvement Network
Better Ideas for Chronic Disease Care

Lessons Learned in the Pioneer ACO Experience: From Promise to Progress

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Performance, Quality, Coordination, Technology, Transformation

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Topics & Outline

- General Concepts
  - Does the model matter
  - Experiment or experience
  - Crossroads or barriers
- Engagement
  - Networking
  - Providers, beneficiaries, others
- Heritage California Approach
  - Care coordination
  - Trials and best practice
  - Quality is job won

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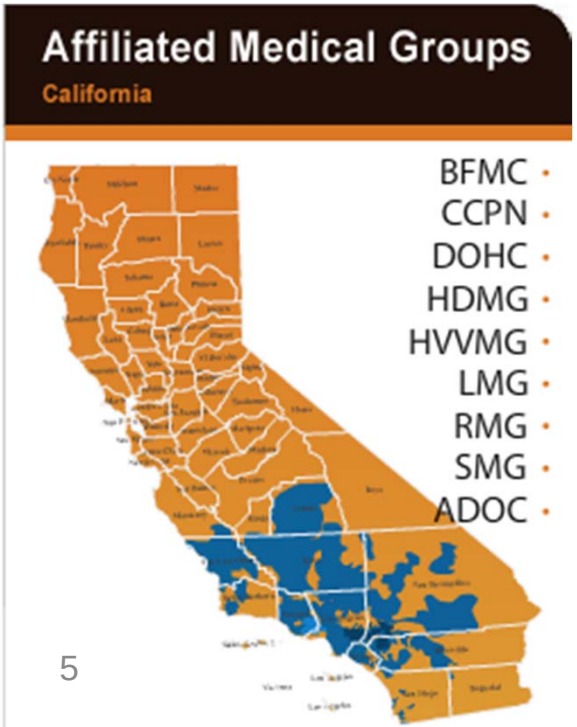
About Us

Heritage California ACO is operated by the Heritage Provider Network (HPN) family of organizations, which was founded in 1979 by Dr. Richard Merkin, president and CEO. HPN and its affiliated medical groups nourish the physician-patient relationship, providing the foundation for quality health care.



- One of the largest healthcare delivery networks in California
- Network spans from San Luis Obispo and Tulare Counties to the north, San Diego County to the south, Riverside and San Bernardino Counties to the east, and the ocean to the west
- Manages the care of approximately 700,000 individuals
- Contracts with approximately 2,300 primary care providers, 30,000 specialists, and over 100 hospitals
- Employs hundreds of physicians at our own group clinics
- Licensed by the State of California as a health plan that allows us to accept global risk (both professional and institutional risk)
- Almost 90,000 Pioneer ACO lives

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Knowledge Powered Proposition

- Clinical systems, administrative systems, data support
- Track record of success
- Centralized care team resources at the group level
- Ability and willingness to engage beneficiary population
  - 1 in 5 patients can identify physician in charge of their care
  - 20% delta between PCP's who believe patients know their Dx and those who say they do
- Change from productivity-based payment model
- History of trust

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Strategies for Successful Implementation

- Meet with providers personally to explain the ACO and answer their questions
- Hold and continue to hold provider "Town Hall" meetings or forums
  - Increase communication on ACO (newsletters, office manager meetings, physician group meetings)
- Make multiple presentations to primary care groups, specialty groups, and hospitals (offer an ACO University)
- Demonstrate the potential for shared savings with no downside financial risk
- Make it clear we will do the heavy lifting with regard to hospital care, case management, care coordination and after hours care, etc.
- Ask providers to rely on the trusted relationships developed over the years through our HMO, PPO and MA business

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Transitions in ACO Maturation

- No financial risk, no process delegation
  - Small solo practice(s)
- Some financial risk, some process delegation
  - Larger group practices or specialty vendors, some degree of clinical and administrative systems
  - EHR, communication, and data sharing capability
  - Integrate into centralized care models where possible
- High financial risk, significant process delegation
  - Sub-ACO's
  - Hospitals, integrated group networks, specialty vendors – sophisticated programs and processes
  - Leverage strengths and build synergies on enterprise wide improvements

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Strategies for Successful Implementation

- Utilize "friendly and influential" physicians to help explain and get the word out about the ACO
- Educate physicians on health care reform allowing them the opportunity to proactively position themselves as health care moves toward population management, medical homes, ACOs, and bundle payments, etc.
- Foster an enterprise wide commitment to the ACO
- Devote adequate resources
  - Be visible
  - Keep the process simple for the provider office
- Celebrate the "beneficiary" victories

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Compensation Approach at HCACO

- Same for salaried, IPA physicians and both PCP and Specialists (with the exception to large specialty or multi-specialty groups)
- First X% of savings is distributed to all providers based on the provider's annual Medicare reimbursement for each beneficiary aligned to that provider
- Any savings beyond the first X% above is divided between the provider and Heritage California ACO
  - After HCACO is reimbursed equivalent amount distributed to providers
- Developing a quality performance incentive payment structure based on the required quality metrics and patient satisfaction measures

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Early Compensation Model: PCPs vs. Specialists

Individual PCPs/Specialists

- No difference in the distribution of shared savings
- First X% of savings goes back to the providers
- Additional savings are divided between the provider and Heritage California ACO based on a percentage allocation
  - After HCACO reimbursed equivalent amount distributed to providers

Large Multi-Specialty or Specialty Groups

- Benchmarked against their own aligned beneficiaries
- Less X% for administrative expenses
- May or may not be an upfront payment or bonus that is offset against future shared savings
- Shared savings divided between the Group and Heritage California ACO in varying percentages
- Group may share in downside risk

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Typical Engagement Scenario

- Explain the Pioneer ACO program and purpose.
- Make sure the provider(s) understand(s) this is not an HMO. Beneficiaries aligned with Heritage California ACO are still FFS Medicare beneficiaries.
- Explain that there is no utilization management or prior authorization approval process. FFS beneficiaries are still free to choose any doctor at any time.
- Let them know we are not changing the way they bill or get reimbursed from CMS for FFS Medicare business. Providers will continue to bill CMS and get paid by CMS for at least the first two years.
- Explain the beneficiary alignment process.
  - The ACO helps keep beneficiaries aligned with the PCP
- Explain the benchmark and how shared savings can be achieved.
- Let the provider know Heritage California ACO is not asking for any capital funding now or in the future.
- Provider still center of care (keep them informed, provide information, notify of admissions, steer beneficiary back to provider post discharge).

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Typical Engagement Scenario (continued)

- Demonstrate how the first X% of savings is passed down to the provider based on their annual CMS reimbursement. (For example, if your annual reimbursement was $30,000 for a specific beneficiary assigned to you then you would receive an additional amount of shared savings equal X% times $30,000).
- Any savings beyond the first X% above will be divided between the provider and Heritage California ACO (after HCACO is reimbursed equivalent amount).
- Make sure the provider understands there is no downside risk. If the ACO doesn't meet CMS's benchmark, Heritage will pay 100% of any losses. There will be no attempt to collect money from the provider.
- Offer the provider access and help with EHR.
- Stress the fact we are simply offering them and their Medicare FFS beneficiaries the same education, disease management, and care programs that HMO patients enjoy for FREE as an added benefit.
- As a result, the provider can enjoy better monitoring and better sharing of medical information that directly influences better health for their patients.

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Care Coordination Lessons

- Risk stratification
- Beneficiary engagement
- Building a "brand" and a need
- Quality over quantity is an ACO theme
- The difference between MA and ACO
- Transitions in care coordination delivery

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Changes to the Provider Compensation Model

Past

- Based on FFS Medicare allowable rates

Future

- Based on FFS Medicare allowable rates with quality adjustments
- Potential for partial capitation, but must have beneficiary incentives (or more skin in the game) to stay in network

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Care Coordination and Transition Strategies

- Reducing
- Managing
- Supporting
- Identifying
- Measuring

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Reducing Transitions

Analyze Data *no less than* Monthly
Once Identified *must* Coordinate Transition Points

HCACO Tools & Strategies
Inpatient Management and Discharge Plan
Ambulatory Care Coordination Outreach and Care Plan

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Managing Transitions

Identification of Planned Transitions

Timely Communication of Transition Care Plans to All Stakeholders

Review Follow Up Instructions *within 72 Hours*

Focus on Self-Management Requirements

Reconcile Medications *within 3-10 Days*

HCACO Tools & Strategies

Inpatient Management and Discharge Plan

Ambulatory Care Coordination Outreach and Care Plan

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Supporting Transitions

Timely Communication About the Transition To Include:

- Any New or Continuing Treatments,
- Timeframes Related to the Transition
- Durable Medical Equipment Needs
- Skilled Care such as Wound or IV Therapy
- Restorative Therapy such as PT, OT, ST
- Follow Up Appointments
- Self Management Requirements

HCACO Tools & Strategies

- Inpatient Management and Discharge Plan
- Ambulatory Care Coordination Outreach and Care Plan

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Identifying Unplanned Transitions

Timely Reports of:

- ED Encounters
- Hospital Admissions
- Skilled Admissions
- LTC Admissions
- Ambulance Encounters

HCACO Tools & Strategies

- Eligibility Verification

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Measuring Performance

Admission & ED Statistics
Care Plan & Transition Measures
Clinical Measures (Chronic & Preventive)
Behavioral Health Measures
Beneficiary Experience (Feedback)

<u>HCACO Tools & Strategies</u>
q.Analytics
q.Metrics

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Takeaways

- Communicate, communicate, communicate
- Educate your providers about ACO programs and where health reform is headed
- Need to integrate quality metrics into shared savings calculations and future reimbursement methodologies

Thank you for joining our call today!

For more information about the California Improvement Network, go to www.chcf.org/california-improvement-network

Today's webinar slides and recording will be available at that site within a week.

California Improvement Network Better Ideas for Chronic Disease Care