

# Clinical Integration and Healthcare Reform

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## *The Way Forward*

**Valence**   
Health

# Today's Speakers

- **Carole Black, MD, Chief Medical Officer**

Dr. Black has more than 25 years experience in health care management and as a practicing internist; having served in physician leadership roles and as a medical director in health plans and health systems. Dr. Black is a thought leader in clinical integration and early adopter Accountable Care Organizations.

- **Lori Fox Ward, Vice President, Clinical Integration**

Ms. Ward is a registered nurse with 20 years of experience in the managed care industry working with providers, health plans and employers. She has designed and led numerous clinical integration programs for a wide range of provider organizations.

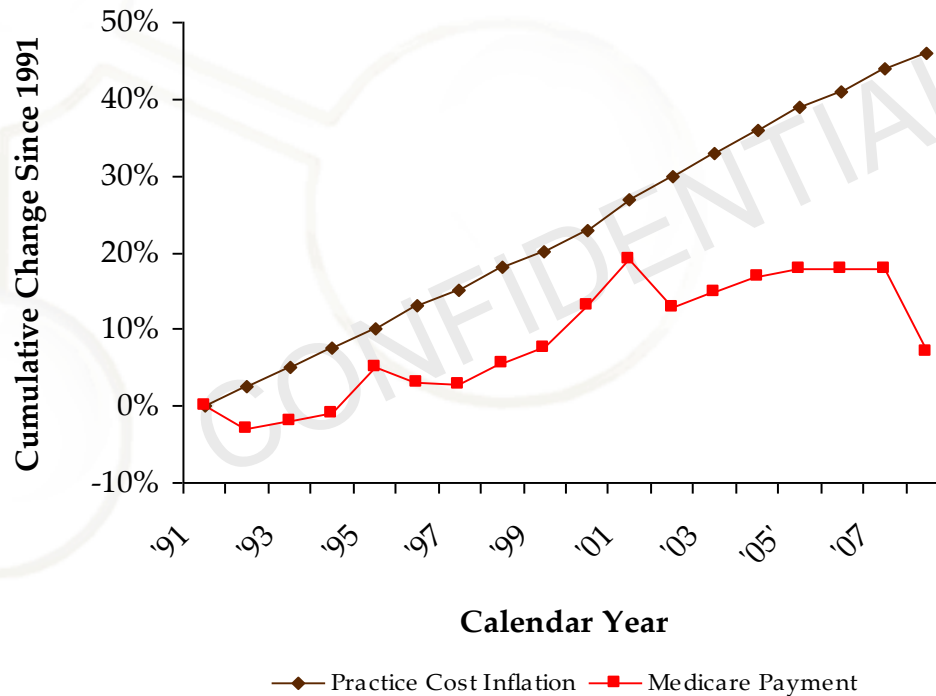
- **Elizabeth Simpkin, Vice President, Consulting Services**

Ms. Simpkin has over 20 years of experience in managed care contracting, strategic planning, and business development, assisting leaders of provider organizations improve and demonstrate quality of care to strengthen their market position.

# Today's topics

- **Today's environment**
- **Health Care Reform: the Patient Protection and Affordable Care Act**
- **Organizing to succeed in the new environment**
- **Clinical Integration and the Way Forward**

# Practices are challenged with Less Revenue and More Expense ...



## The “Less Revenue, More Expense” scenario impacts hospitals as well ...

- More uninsured patients
- Decreased investment revenue
- Fewer elective admissions and procedures
- More audit impacts and compliance requirements
- Non-payment for errors and complications
- Higher operating costs, hiring freezes
- Less capital, delaying projects



# A Sea Change is Needed ...

- **BEND THE TREND** – decrease total healthcare expense & the rate of increase
- **IMPROVE MARGINS** for providers

# And the Key Tactics include:

- Focus on, and pay for, *value* – quality and cost
- Decrease errors, inefficiency and waste
- Facilitate evidence-based medical practice
- Expand access – reduce disparities
- Support coordinated, integrated care delivery:
  - Accountable Care Organizations
  - Bundled payments



# Health Care Reform Legislation

- **Patient Protection and Affordable Care Act**  
enacted March 23, 2010
- **Health Care and Education Affordability Act**  
enacted March 30, 2010

## **The Big Picture – Major Aspects of Reform**

- **Extends coverage to 32 million uninsured Americans**
- **Insurance market reforms**
- **Individual and employer mandates for coverage**
- **Health Insurance Exchanges**
- **Medicaid expansion**
- **Medicare reform**
- **\$938 billion over 10 years**

## The Plan: 6 Key Components ... and 6 Years

- 1. Payment Reform and Insurance Reform**
- 2. Mandatory Coverage with shared responsibility**
- 3. Primary Care Growth/Access**
- 4. New Care Coordination & Reimbursement Models**
- 5. Value Based Purchasing for Hospitals**
- 6. Linking of \$ to Quality/Safety Outcomes**

# 2010

## **Insurance Reforms:**

Create temporary high risk pool to provide coverage for individuals with pre-existing conditions; provide dependent coverage for children through age 26; prohibit rescissions and lifetime benefit limits; require plans to report MLR

## **Fraud and Abuse:**

Significant increases to fraud and abuse funding, coupled with increased financial penalties

## **Small business tax credits:**

Small business tax credits to purchase health insurance for employees.

## **Hospital Payment Updates:**

Reduces the hospital Medicare payment update by 0.25% in April 2010, with additional decreases to follow annually

## **Physician Quality Reporting Initiative:**

Extends PQRI beyond 2010

# 2011

## **Quality Improvement:**

National quality improvement strategy that includes priorities to improve the delivery of health care services, patient health outcomes and population health; Establish Community-based Collaborative Care Network Program to support consortiums of providers to improve care delivery to low-income populations

## **Primary Care payment increase:**

10% bonus in Medicare reimbursement for primary care physicians and general surgeons in health shortage areas

## **Innovation Center:**

Creates Center for Medicare and Medicaid Innovation to test new payment and delivery models

# 2012

**Administrative Simplification:**

Encourages uniformity to improve health care system operations and reduce administrative costs

**Accountable Care Organizations (ACOs):**

Allows for the sharing of savings from improved care management with hospitals and physicians that voluntarily work together to manage care

**Value-Based Purchasing (VBP):**

Establishes a VBP program for hospital payments beginning in FY2013 based on 2012 performance based on measures that are part of the hospital quality reporting program

**Medicaid:**

Create demonstration projects for bundled payments; global capitation to safety net hospital systems; and pediatric ACOs to share in cost savings

# 2013

## **Medicare Bundled Payments:**

Establishes a national, voluntary pilot program on bundling payments to providers around 10 conditions; expand program if appropriate in 2016

## **Readmissions:**

Imposes financial penalties on hospitals for “excess” readmissions when compared to “expected” levels of readmission

## **Primary Care Physicians:**

Requires states to increase Medicaid payment rates to primary care providers to Medicare levels

## **Medicaid payments:**

Increase Medicaid payments to primary care doctors

# 2014

## **Individual and Business Mandate:**

Requires individuals to purchase health insurance or face a tax penalty; businesses to offer coverage or pay penalties

## **Health Insurance Exchanges:**

States are required to establish exchanges through which individuals and small businesses can purchase qualified insurance coverage

## **Health Insurance Reforms:**

Prohibits health insurers from excluding coverage based on pre-existing conditions, places limits on premium ratings and requires that coverage be issued to all who seek it; reduce out-of-pocket limits for those under 400% FPL; limit deductibles to \$2000 individual/\$4000 family

## **Medicaid:**

Expand Medicaid to cover individuals up to 133% of federal poverty level

## **Disproportionate Share Hospitals (DSH):**

Decreases Medicaid DSH payments by \$14B and Medicare DSH payments by \$22B

## **Independent Payment Advisory Board (IPAB):**

Creates independent board that will make *binding* recommendations on Medicare payment policy (hospital payments excluded from IPAB oversight through 2019)

# 2015

**Hospital-Acquired Conditions (HACs):**

Penalizes hospitals in top quartile of HACs by 1%

**Bundled Payments:**

Expands voluntary bundled payment pilot programs established in 2013

**Medicare DSH payments:**

Reductions of \$36B over 10 years beginning in 2015

# HITECH Act

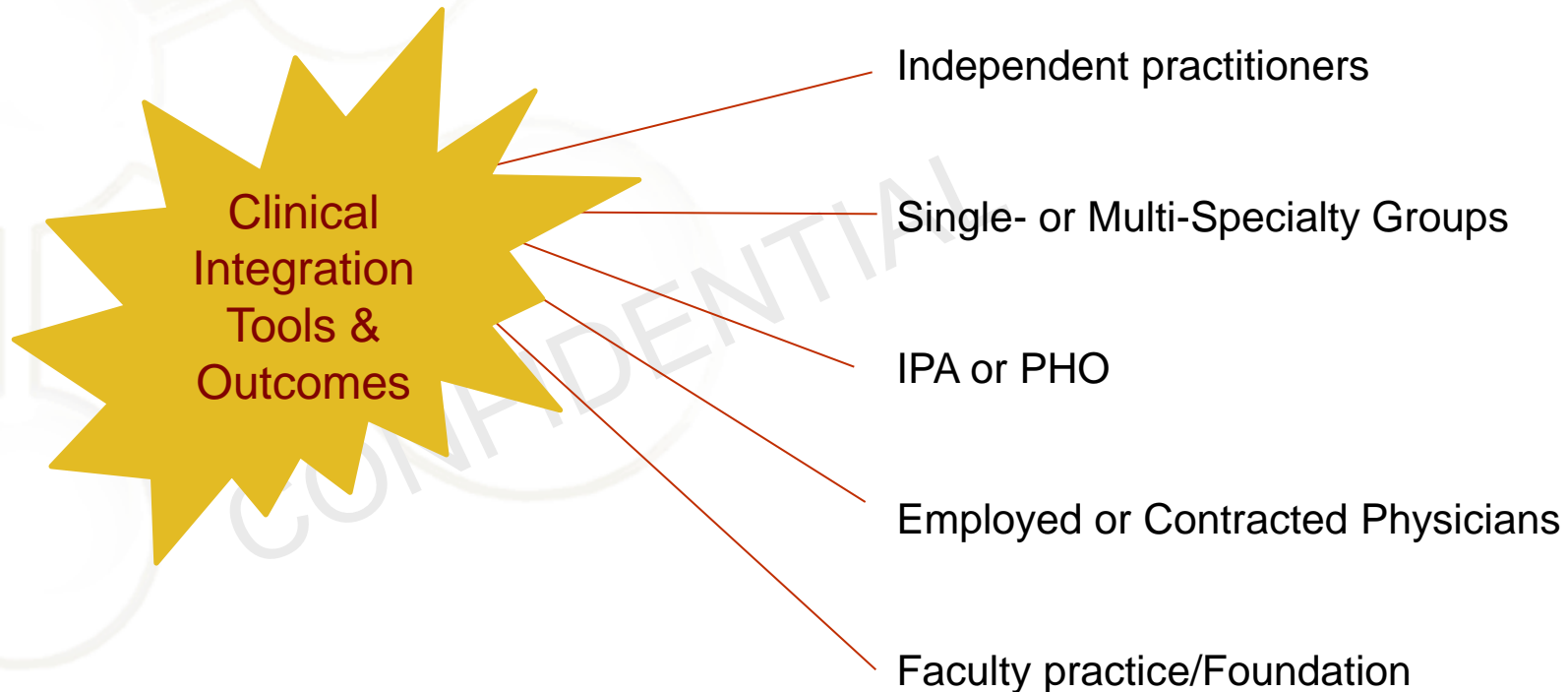
- Not strictly part of health care reform, but critical to physicians and important for success under reform
- Pressure to adopt EHR and meet “meaningful use” standards in order to earn incentive
- Penalties for non-adoption beginning in 2015

Year of Certified EHR Technology Adoption	2011	2012	2013	2014	2015	2016	Total Payment
2011	\$18,000	\$12,000	\$8,000	\$4,000	\$2,000	0	\$44,000
2012		18,000	12,000	8,000	4,000	0	42,000
2013			15,000	12,000	8,000	0	35,000
2014				12,000	8,000	0	20,000
2015					0	0	0

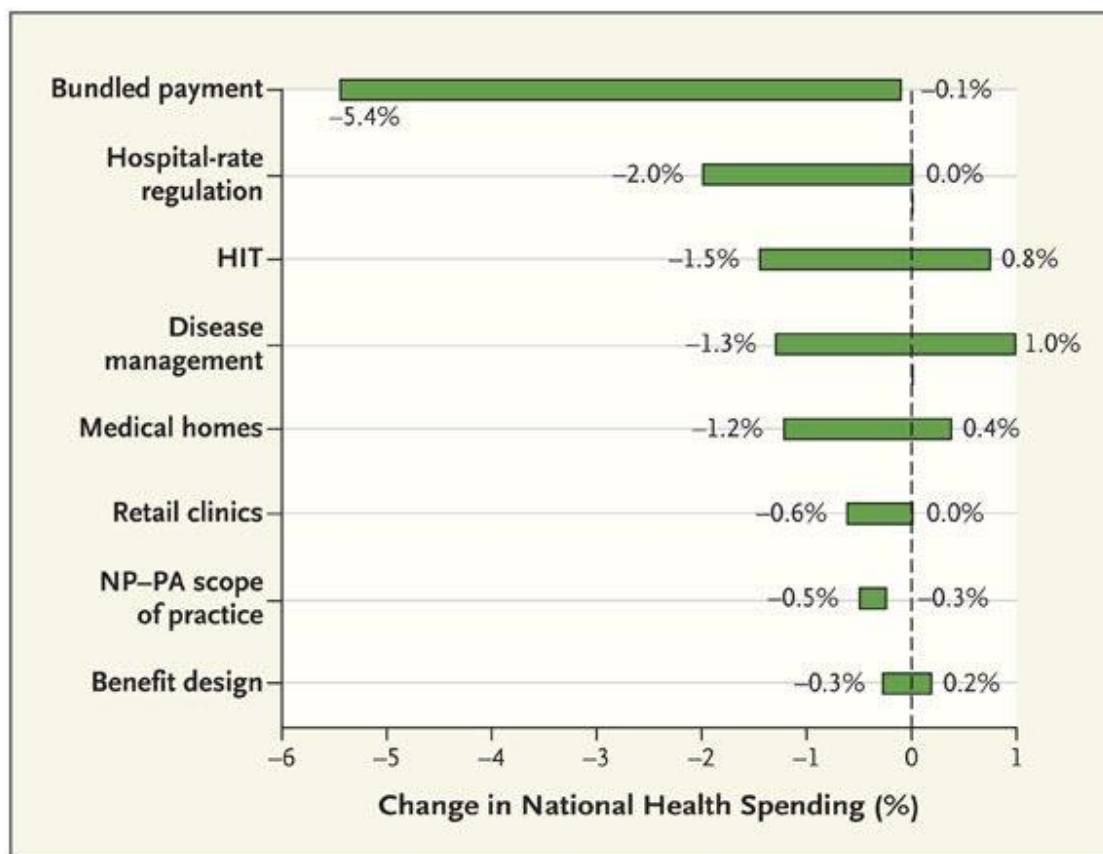
# Payment Reform - Pay for Integrated Care

- **Expect Congress to solve current SGR problem  
BUT expect downward pressure to continue**
- **Upside potential for providers who are prepared to  
manage patients and populations**
  - Bundled payments
  - ACO
  - Capitation
  - Increase in risk arrangements
  - Value-based purchasing

**Partnerships will be created by, and with, Physicians who focus on the delivery of effective, efficient, coordinated care:**



# Where will savings be derived?



From the Rand Study, NEJM 11/26/2009

# Bundled Payments

- **Single payment to clinicians and facility for an episode of care**
  - Defined start /stop, and scope of included services
  - Accepted clinical guidelines
  - Providers can be identified (attribution) and can impact utilization and cost
- **Reimbursement allocation managed by providers**
- **Quality metrics and outcomes**
  - With payment adjustments
- **Guaranteed service – no added reimbursement if errors or complications**
- **Data and efficient, effective performance critical to offer and deliver competitive pricing**
  - Physicians and Facility must partner to succeed

# Bundled Payments

## Implications:

- CMS/Medicare is very interested and engaged
- Successful execution is complicated
- Contracted entities will be at [significant] risk based on outcomes
- Will require facility/physician cooperation
- Payment allocation will be challenging
- Physician participation and engagement will be crucial
- Measurement will be a key component, and complex
  - Monitoring of care process real time during an episode: gaps; rough idea of accumulating utilization; outlier identification and intervention
  - Results tracking → defect identification/outcomes monitoring
  - Impact of interventions

# Medical Home

- **Focus is on Care Management/Delivery for a population organized around the Primary Care practice**
  - Care management capability and staffing embedded in the Primary Care practices
  - May require supplemental payer/facility/system expertise
- **Tools, data and supports to understand case mix, stratify risk, tailor interventions, and monitor results**
- **Reimbursement methodologies to recognize and reward care coordination activities and outcomes**
  - May be FFS with added pmpm for care coordination and/or performance incentives

# Medical Home

- **Requires Primary Care network**
- **It takes a “village” – the care team**
  - Pre-visit chart review & visit planning
  - Dedicated time for patient follow-up
  - Re-engage “lost” patients
  - Enhanced access to the care team
  - Patient Empowerment
- **Real-time access to practice management data is a necessity**
  - Patient registry
  - Gaps in care
  - Results tracking
  - Integration across providers
  - Standardized care approaches (Guidelines)

# Accountable Care Organizations

- **By definition, ACOs are physician-driven**
  - Groups of Physicians or Physicians with hospital(s)
- **Current model features a “Shared Savings” incentive**
  - May/likely will evolve to include risk +/- or capitation

# ACO Functions:

- **Organization of clinical activities**
- **Local accountability**
- **Measurement, tracking, reporting of longitudinal outcomes and costs**
- **Distribution of savings after FFS payments**
  - Goal is savings compared to prior baseline
  - Distribution mechanisms could vary (FFS w/withhold <-> “cap”)
  - May transition to some form of bundled payments

# ACO Components

- **Collection of physicians operating as a “group”**
  - Clinical care coordination & operations/business management
  - Arrangements for facility care (hospital, SNF, LTAC, health center, etc.)
- **Medical home approach for primary care**
- **Financial management program**
- **IT infrastructure plan**
- **Clinical Integration with a Medical Management plan/program**
- **Effective leadership and supportive culture**
- **Market endorsement**

# ACO Features:

- Define process to promote care quality: guidelines
- Report on costs and care quality
- Management/leadership structure for decision making
- Formal legal structure to allow receipt/handling of incentive \$
- Include PCPs of at least 5000 Medicare patients
- Provide CMS with a list of participating PCPs and Specialists
- Contract with a core group of specialists
- Participate for a minimum of 3 years
  
- State/local pilot options which are considering risk and discussing limited networks in exchange for lower employer costs

# ACO Competencies

Leadership &  
Governance

Operations

Clinical  
Management

Infrastructure  
and IT

Risk  
Assessment

Work Force

# Primary Care Capacity issues

- **Influx of newly covered patients**
- **Greater coordinating role under most models**
  - Patient Centered Medical Home, ACOs, bundled payments, capitation
- **Requires practice adjustments and staffing changes**
  - Physician extenders to provide services
  - Phone triage to divert services
  - Resources to outreach to patients and coordinate with other providers

# Positioning for the future

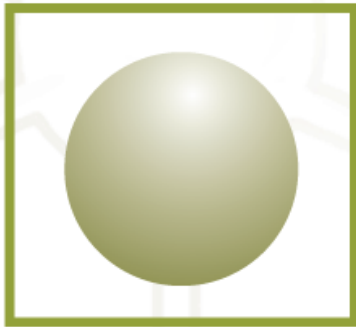
- **Success in the new payment models**
  - High quality and appropriate utilization are valued
  - Performance demonstrated through quality metrics
  - Care coordination among hospitals and providers is critical
  - Organized, clinically integrated entities fit the model

# Essential to Success



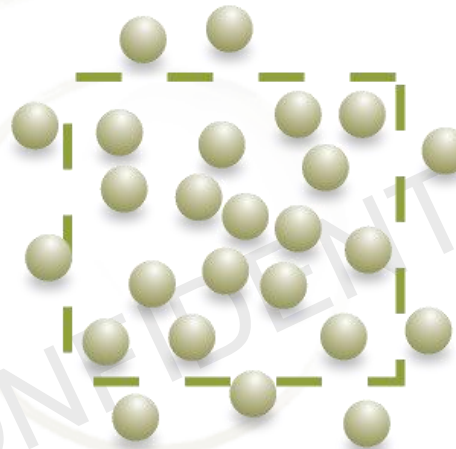
# The challenge of integrating care

## *Integrated Systems*

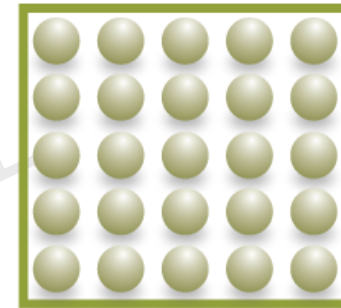


- Cleveland Clinic
- Geisinger
- Mayo Clinic

## *Typical Networks*



## *Clinically Integrated Networks*



- Partners Health Care
- GRIPA
- Tri State Partners
- Advocate Health Partners
- Adventist Midwest
- St. Luke's IPA
- PHS

# Clinical Integration as the Unifying Vehicle

- Real time data availability
- Knowledge transfer across care delivery sites
- Coordination among clinicians
- Common protocols and shared clinical goals
- Accountability among colleagues
- Aligned incentives
- Infrastructure to support performance improvement

# Clinical Integration

- **Organized Provider Group that:**
  - Agrees on how care should be provided
  - Measures actual performance
  - Compares actual to agreed upon performance
  - Addresses providers that do not meet standards
- **When sufficiently developed, allows independent physicians to negotiate contracts collectively**

# Another definition

- **“... 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.”**

*Taken from Statement of Antitrust Enforcement Policy in Health Care,  
FTC & DOJ, August 1996*

# Value Proposition

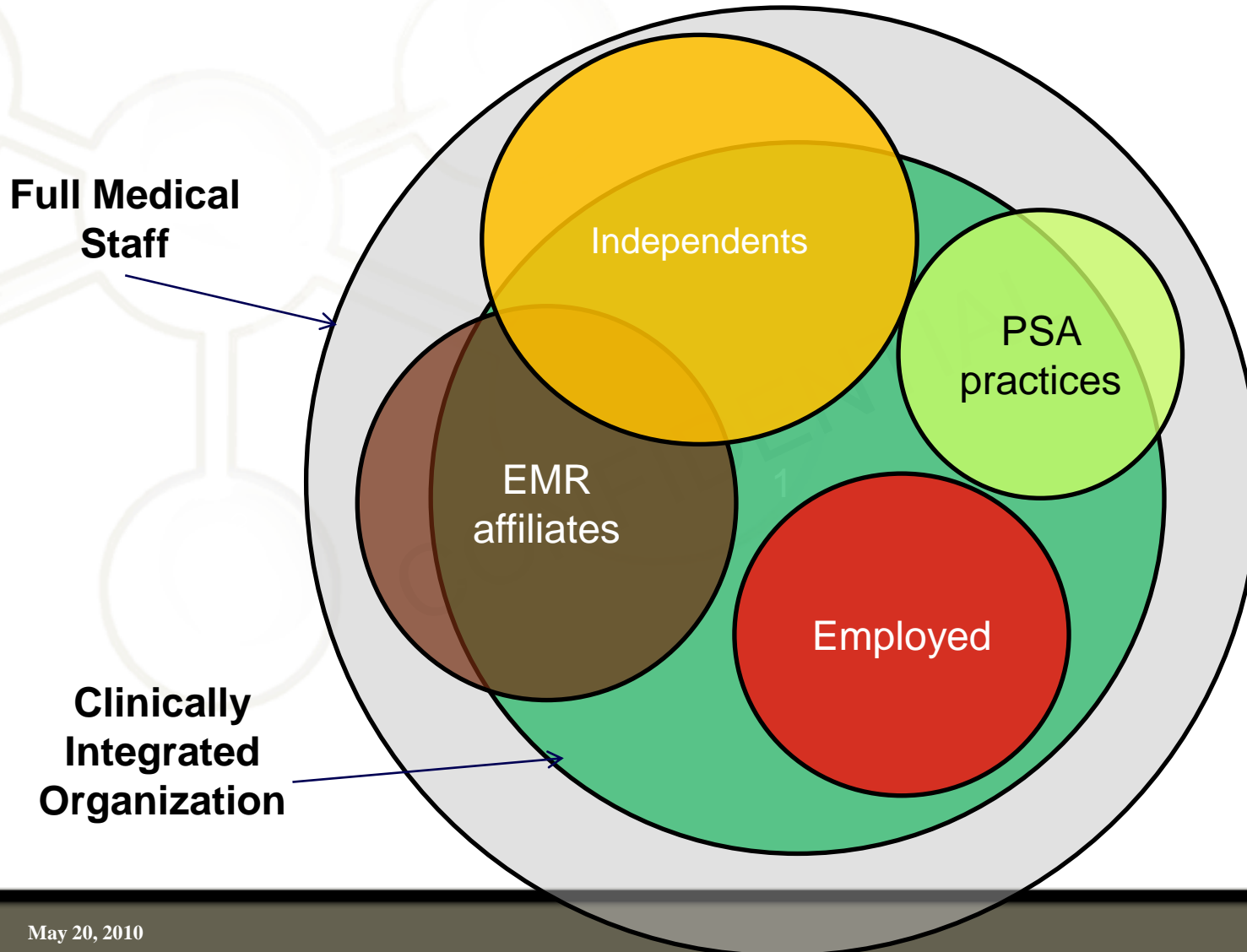
## Value to Hospital

- Provide a vehicle for integration across all physician segments
- Joint contracting for physicians and hospital
- Prepare for ACOs and new payment models
- Brand and market the entire system including physicians

## Value to Physicians

- Joint contracting
- Prepare for new payment models – Bundled payments, ACOs, Medical Home
- Alternative to payor “scorecards”
- Demonstrate quality and efficiency across care settings

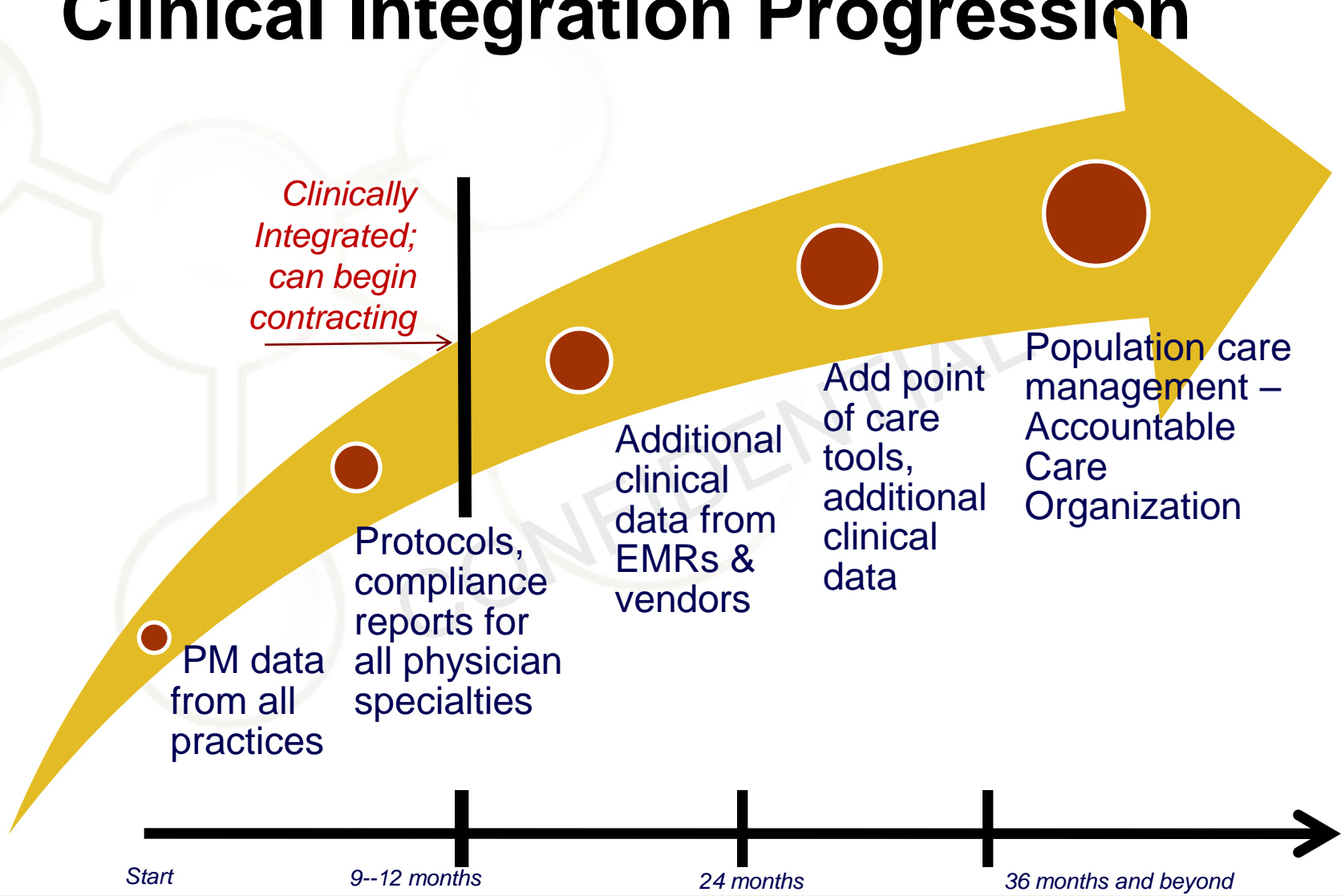
# Vehicles for physician alignment



# Key Steps to Clinically Integrate

- **Understand organization characteristics**
- **Engage with physicians**
- **Determine data collection methodologies**
- **Select Clinical Protocols**
- **Provide meaningful reports and proactive care management tools**
- **Consider ACO or other demonstration project**
- **Legal support throughout**

# Clinical Integration Progression



# Finally...to summarize...

- The old (“FFS”) environment is changing
- Change is here, though details are being refined
- Opportunities are abundant, but...
- Creativity and breakthroughs will be needed
- Relationships and partnerships will evolve
- Understanding clinical complexity and having complete data available will be key

*Clinical Integration to support coordinated care delivery will be crucial*

# Valence<sup>®</sup> Health

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*Clinical Integration:  
Different Approaches...  
Common Goals*



# THANK YOU !

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