AHA Physician Leadership in Clinical Integration – Discussion Document

Clinical Integration/Physician Alignment — CIO Models

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Presentation Overview

1) Drivers and Challenges in Health Care Today

2) “Meaningful Clinical Integration”

3) Clinical Integration Drives Physician Alignment
   − Clinically Integrated Organizational (CIOs) Models

4) CIO Administrative Development
   − Structure
   − Organization
   − Funds Flow

5) Clinical Integration Organization Formation Initiatives
   − CIO “Core Element” Project/Process
   − Physician Organization” Project/Process
   − “Medical Staff Collaboration” Project/Process

6) ACOs – To Be or Not To Be...

7) Conclusions

8) Appendix
Drivers and Challenges in Health Care Today

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Navigating the Perfect Storm

U.S.S. Healthcare System

Too many patients

Too little funding

Too few professionals

Too much cost
### Past/Current Governmental Impacts

<table>
<thead>
<tr>
<th><strong>Balanced Budget Act (1997)</strong></th>
<th><strong>Tax Relief and Health Care Act (2006)</strong></th>
</tr>
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<tbody>
<tr>
<td>Sustainable Growth Rate (SGR) established, now a $250+ billion underfunded liability related to physician reimbursement rates</td>
<td>Medicare Medical Home Project begins in up to eight states in 2009</td>
</tr>
</tbody>
</table>

| **Medicare Modernization Act (2003)** |
| Medicare Part D Prescription Drug Benefit Transition to MS-DRGs |

| **Deficit Reduction Act (2005)** |
| Decreased reimbursement for office-based ancillaries starting January 2007 |

| **Patient Protection and Affordable Care Act (2010)** |
| Multiple elements phasing in from 2010-2019 with significant, across-the-board impacts on health plans, hospitals and physicians |

| **Supreme Court** |
| to hear 5+ hours of testimony on ACA constitutionality March 2012, with a judicial decision anticipated on three key issues—“Individual Mandate”, “Medicaid Mandates” and “Severability”—by June 2012 |

| **Insurance Exchanges Go Live (2014) or Not** |
| Regardless of whether 30 million Americans or less enter state based insurance exchanges virtually all reimbursement structures are migrating to “Value-Based” |

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### BOTTOM LINE

Profound changes ahead for all health care organizations

**Legislation**  **Regulations**  **Guidelines**  **Opinions**  **Rulings**

**Changing by the month**
Reforms Accelerate Access for Millions of New Patients and Development of Value-Based Plans

- Under ACA, an estimated 32MM people will get coverage:
  - 15MM more covered by Medicaid
  - 15MM more covered by health insurance exchanges
  - Medicare population will grow by 15MM over next decade
- Uninsured drops to approximately 23MM (mainly undocumented workers or people who choose not to seek coverage)
- “Value-Based” Reimbursement is the dominant provider payment

FFS is Evolving to “Value-Based” Reimbursement/Plans and Requires a CIO Structure of Some Type for FTC Compliance

CURRENT SYSTEM
Fee-for-Service
- Reward volume over value of services
- Less than optimal to distinction of differences in quality of care even with typical performance metrics
- Spotlight inequities in access
- Limit physician/patient face time to deal with complex or challenging conditions
- Discourage coordination of care over time and across the continuum of care
- Undermine strong physician/patient relationships and team-based care

REFORMS TO REDUCE COSTS
“Value-Based” Payment
- Clinically Integrated Organizations positioned to optimize reimbursement changes and quality requirements
- CIO Structure is just not just a new “PHO” (e.g., contracting entity). Real “Clinical Glue” is necessary for Value-Based Payment to stand up to FTC review.
- Mobility of Care- Taking the right care to right place as well as optimizing existing bricks and mortar
  - Pay for “Care Management”
  - Pay based on evidence-based care
  - Payments tied to measurable standards clear to providers and consumers
“Clinically Integrated Organizations” (CIOs) Provide the Structure for FFS to Evolve to Value-Based Networks/Plans

Minimum Requirements for an Integrated Health System Structure to be a “CIO”

- It must be a legal entity such as an LLC, 501(c)3, etc. that can enter into all types of physician/hospital reimbursement contractual relationships (e.g., FFS, “Value-Based”, Capitation).

- It must have as a priority achieving “Meaningful Clinical Integration” status as reviewed by the FTC, DOJ and HHS by 2014 (to participate in state based “Insurance Exchanges”).

- It must support “next generation” care models compatible with participation/sponsorship of ACO, CMS Bundled Payments, and Medical Home Initiatives.

- The terms CIO and ACO are often used interchangeably, that is not technically correct. A “ACO” today has CMS/Medicare as a payer. In most instances it needs to be a “CIO” but a “CIO” does not need to be an “ACO” but often will be.
“Clinically Integrated Organization” Common Elements
– VB Plans Have Tiers of Lower Cost “Narrow Networks”

1. Physicians (employed and independents) working together
2. Integrating physician practices with hospital practices
3. Integrating key independent ancillary services into mix
4. Evolving interface between health system and payers requires clinical integration
Redistribution of Commercial, Medicaid, Uninsured and Medicare Participants/Revenue (2012 to 2014) – Example

2012

- **Commercial** - 45%
  - Commercial Individual
  - Commercial - Sm./Mid Size Group
  - Commercial - Large Group

- **Medicaid** - 18%
  - Medicaid > 133%
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- **Uninsured** - 12%
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  - Uninsured < 133%
  - Undocumented

- **Medicare** - 25%
  - Medicare - FFS
  - Medicare Advantage, etc.

2014

- **Commercial**
  - Commercial and Commercial VBP - 36%
  - Commercial → Exchange
  - Medicaid → Exchange
  - Uninsured → Exchange
  - Commercial → Medicaid
  - Remaining Commercial
  - Medicaid → Exchange
  - Remaining Medicaid
  - Medicaid VBP - 24%

- **Uninsured**
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  - Remaining Uninsured
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* Developed from SSB Proprietary Data Base 2012
Value-Based Plan
– Tiered Network Clinical/Financial Implications

The Risk Continuum Associated With Existing and Proposed Reimbursement Structures

**Tier 1** – FTC Compatible Meaningful Clinical Integration Infrastructure-Baseline Large Network

**Tier 2** – CIO Network at least 20% Smaller Than Tier 1 with more advanced CI capabilities

**Tier 3** – CIO Network at least 40% Smaller Than Tier 1 & Capable of Global Payments with Performance Risk, P4P, etc.

**Tier 4** – CIO Network at Least 60% Smaller Than Tier 1 and capable of accepting Global Payment with Financial Risk (e.g. MA Capability)

- Consumers
- Employers
- Health Plans
- Government Payors

*Modified from HFMA materials with SSB Solutions, Inc. proprietary data base*
Managing Reimbursement Increasingly Complex – FFS Decreasing while Tiered VB/CIO Revenue Increasing

Alternative reimbursement methodologies will occur simultaneously and require different types of physician/hospital alignment models.
Profitability Crisis for Physicians/Hospitals Drive New Efforts to Clinically Integrate for “Value-Based” Plans

- **Revenues and expenses per enrollees**
- **Cost of care increasing 7-9% annually**
- **Declining reimbursement over time**
- **Mounting losses due to medical cost inflation**

**NO ACTION**

**DOING NOTHING IS UNSUSTAINABLE**

- Year 1
- Year 3
- Year 5

Healthcare Revenues
Cost of Care
Healthcare Revenues
Cost of Care
Healthcare Revenues
Cost of Care

Revenues and expenses per enrollees
Clinical Integration Organization Formation Requires At Least “Four Discrete Projects/Processes”

Phasing I – II – III

Clinical Integration Organization Formation Projects (4) in Three Phases

CIO Administrative Project
- Legal structure
- Organization
- Governance
- Committee structure
- Care delivery transformation
- Infrastructure development
- Budgeting/Financial Modeling

"Physician Organization" Project
- Education
- Engagement
- Physician Organization Development? Yes/No
- Aligned & Non-Aligned Physician Dynamic

Clinical Model Development
- Product Specific
- Value Based
- Variable Physician Network Scope/Size

Medical Staff Collaboration Project
- Education
- Engagement
- Structure for collaboration?
- Delegated Functionality

Clinical Model / Model of the Future
- Faculty
- Provider Compensation
- Clinical Transformation
- Enabling Technology
- Mobility of Care Elements in non-traditional settings

Clinical Governance—All Things Clinical
- Credentialing
- Peer Review
- Quality

Full Continuum of Care — Inpatient and Ambulatory Services Care Management
Super Clinical Integration Organization (Super CIO) Maybe Necessary When One CIO Does Not Have Adequate Mass

- CIO #1 Hospitals
- CIO #1 participating physicians
- CIO #1 Co-mgmt. Companies
- Other entities focused on clinical integration/performance

- CIO #2 Hospitals
- CIO #2 participating physicians
- CIO Co-mgmt. Companies
- Other entities focused on clinical integration/performance

- CIO #3 Hospitals
- CIO #3 participating physicians
- CIO #3 Co-mgmt. Companies
- Other entities focused on clinical integration/performance

Super CIO

Performance Standards
Provider Network Support
Support Infrastructure
Other Duties and Responsibilities

Contracts

Revenue

Payers

$$$$$

$$$$$$$

$$$$$$
“Meaningful Clinical Integration”

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What Do We Mean by “Meaningful Clinical Integration”?

**Meaningful Clinical Integration (MCI)**

An FTC-recognized model of physician and hospital contracting that:

- Is based on development of a robust quality improvement program with real accountability among otherwise independent physicians
- Integrates and rewards physician members around a common commitment to quality measures based on scientific evidence

**Importance of MCI Structure**

- Structure needs to comply with regulations (FTC, DOJ and HHS) governing collaboration between MDs and Hospitals

**Key MCI Elements**

- **Clinical Model**: Primary care and specialists in formal care management systems using concepts incorporated in ACOs/Medical Homes
- **Business Model**: Contracting structure able to bill, manage, track and distribute payments from diverse payer contracts (FFS/P4P/bundled payments/value-based purchasing payers)

**Organizational Goal**

“Our active and ongoing program to evaluate and modify the clinical practice patterns of the physician participants so as to create a high degree of interdependence and collaboration among the physicians to control costs and ensure quality.” FTC/DOJ Antitrust Enforcement Policy #8B.1, 1996
Conceptual Overview of MCI Structure

Hospitals and Employed Physicians  
Independent Physicians

MCI Structure Defined by Agreements

Organizational Parameters

<table>
<thead>
<tr>
<th>Clinical Scope</th>
<th>Membership</th>
<th>Performance Improvement</th>
<th>Capital Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Encompasses full continuum of care (inpatient and outpatient settings)</td>
<td>Targeted at physicians whose participation has potential to maximize quality and efficient resource utilization</td>
<td>Designed to improve quality and reduce costs through protocols adherence supported by comprehensive data collection and reporting</td>
<td>Significant investment required to develop and deploy technology infrastructure (clinical and financial) to support improved care delivery</td>
</tr>
</tbody>
</table>

Joint negotiation

Base Reimbursement
Shared Savings
Performance Incentives

Payers

$ $ $
“Meaningful Clinical Integration” Legal Considerations

The assessment of clinical integration is an ongoing process; organizational progress must continue to demonstrate significant integrative efficiencies or risk sanctions.

<table>
<thead>
<tr>
<th>Market Power Concentration</th>
<th>Fraud and Abuse Issues</th>
<th>Licensing/Regulatory Issues</th>
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</thead>
<tbody>
<tr>
<td>• Mergers which materially reduce competition may be subject to challenge</td>
<td></td>
<td></td>
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<tr>
<td>- Aggrieved parties usually complain, e.g., the health plans</td>
<td></td>
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<tr>
<td>- No clear benchmark, but if new entity exceeds 40% of the market, that complaint might find a receptive audience</td>
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<td></td>
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<tr>
<td>• Assessment based on market definition</td>
<td></td>
<td></td>
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<tr>
<td>- Product of geography and competitive alternatives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Anti-Kickback Statute and implications</td>
<td></td>
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<tr>
<td>• Stark rule and implications</td>
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<td></td>
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<tr>
<td>• Resulting requirements</td>
<td></td>
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<tr>
<td>- Cannot pay for referrals</td>
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<tr>
<td>- Must have a fair market value (FMV) contractual arrangement (ownership has its own rules) that is:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Fair market value</td>
<td></td>
<td></td>
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<tr>
<td>• Does not compensate for volume or value of referrals</td>
<td></td>
<td></td>
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<tr>
<td>• At least one-year term</td>
<td></td>
<td></td>
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<tr>
<td>• Corporate practice of medicine doctrine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Prohibits lay entities from employing physicians</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Fee splitting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Prohibits physicians from splitting professional fees with lay entities</td>
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Clinical Integration Drives Physician Alignment

- Clinically Integrated Organizational (CIOs) Models

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Physician/Hospital Alignment Options for Clinical Integration

Market drivers and reimbursement shifts pushing delivery system toward clinical integration models.
## Integration Models for Physicians

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<th>Attributes/Enterprise Orientation</th>
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<tbody>
<tr>
<td><strong>EMPLOYMENT</strong> (Plus variations)</td>
<td>Employment, by the hospital, larger physician group or related organization (payer)</td>
</tr>
<tr>
<td><strong>CO-MANAGEMENT/SPECIALITY CIO</strong></td>
<td>Joint management of a hospital service line and/or operating entities between the hospital and a group of organized physicians</td>
</tr>
<tr>
<td><strong>CLINICALLY INTEGRATED ORGANIZATION</strong></td>
<td>Physician/hospital alignment entity that enables clinical integration needed for value-based contracting and be able to pass FTC review</td>
</tr>
<tr>
<td><strong>JOINT VENTURES</strong></td>
<td>Economic venture where the asset or service are jointly owned by physicians and hospital</td>
</tr>
<tr>
<td><strong>PRACTICE SUPPORT</strong></td>
<td>MSO, loans, recruiting support etc. to assist independent physician/groups practices</td>
</tr>
<tr>
<td><strong>PAYER CONTRACTING</strong></td>
<td>Designed to increase negotiating strength with payers. Increasingly ineffective</td>
</tr>
<tr>
<td><strong>CONTRACTUAL</strong></td>
<td>Specific to single physician or group for a designated services (e.g., medical director)</td>
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“Clinically Integrated Organizations” (CIOs) Provide the Structure for FFS to Evolve to Value-Based Networks/Plans

Clinically Integrated Organization (CIO) (e.g. VB Network, ACO, etc.)

“Meaningful Clinical Integration”

Fee-for-Service “Value-based”

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The “Clinically Integrated Organization (CIO)” requires Physician Leadership and Engagement at Multiple Levels

Physician Leadership Requirements for a “CIO”

- Governance: Physician Leadership at the Board of Managers (LLC) or Board of Directors plus Board Sub Committee Leadership (e.g. Quality)

- Management: A strong Physician CEO or President of the CIO is “key” to accelerating and managing physician engagement at all levels

- Operations: Medical Group/IPA/Network Clinical and Financial Performance is driven by physicians clearly understanding what clinical and financial endpoint expectations

- CIO/ACO: Very specific Physician Leadership needs related to sophisticated care models for complex senior and special needs populations

- Commercial VBP Exchange Products: Physician Leadership required to meet VBP targets
"Clinically Integrated Organization" Common Elements – VB Plans Have Tiers of Lower Cost “Narrow Networks”

1. Physicians (employed and independents) working together
2. Integrating physician practices with hospital practices
3. Integrating key independent ancillary services into mix
4. Evolving interface between health system and payers requires clinical Integration

Clinically Integrated Organization (CIO) (e.g. VB Network, ACO, etc.)

Independent Medical Staff and/or IPA and/or Specialty CIO

Employed Physicians

Hospital Facilities (Hospitals/ASCs/JVs)

PHO Physicians and/or Specialty Networks

“Value-based” Fee-for-Service

“Meaningful Clinical Integration”

Payers

$ $ $
Southwest Clinical Integration Strategy – Example

Southwest Medical Group
100 PCPs/900 Specialists

Southwest Independent Medical Staff (2,000+) and IPA
(150 PCPs/500 Specialists)

Southwest Health Network/CIO
Taxable NFP Entity with Four Owners
2200+ Physicians/14 Hospitals

Southwest Facilities
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Evolving interface between health system and payers requires clinical integration

Physicians (employed and independents) working together

Integrating physician practices with hospital practices

Payers

Fee-for-Service

“Value-based”
Southwest Health Network/Aetna Integration Strategy – Example

Southwest Health Network supporting payer/provider integration strategy
Humana 15 Percent Solution

Humana Value Based Purchasing approach, together with the scale needed to execute in a post-reform environment, positions them well to deal with wasteful spending in the health system that has been estimated at more than half of all health spending.*

1% to 2%

**Early Identification**
- Health Assessment
- Predictive modeling

**Provider Contracting**
- Efficient physician networks
- Efficient hospital contracting
- Discounts for free-standing facilities and ancillary services

3% to 4%

**Clinical Integration**
- Provider guidance
- Clinician-based support
- Wellness and productivity
- Pharmacy solutions

**Claims Cost Management**
- Consistent application of Medicare-published local coverage determinations
- Timely DRG audits and recoveries
- Specialized physician billing review software
- Observation status review
- Fraud detection

1% to 2%

**Clinical Integration & Guidance**

**The 15% Solution**

*PricewaterhouseCoopers’ Health Research Institute, 2008*
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- Employers
- Health Plans
- Government Payors

- Physicians
- Medical Groups
- Hospitals
- Other Providers

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CIO Administrative Development
- Structure
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Clinical Integration Organization Formation Requires At Least “Four Discrete Projects/Processes”

Clinical Integration Organization Formation Projects (4) in Three Phases

CIO Administrative Project
- Legal structure
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- Delegated Functionality

Clinical Model / Model of the Future
- Faculty
- Provider Compensation
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- Mobility of Care Elements in non-traditional settings

Full Continuum of Care — Inpatient and Ambulatory Services Care Management

Phasing I – II – III

Clinical Model Development
- Product Specific
- Value Based
- Variable Physician Network Scope/Size
Health systems transforming into a value-based, CIOs must focus on essential components.

- Develop and mature the CIO network to align across the health plan/CMS product continuum to enable maximum health system flexibility/options.
- Create a “One Enterprise” culture for creating shared accountability and risk/reward.
- The Clinical Models will change with an increased emphasis on implementation of evidence-based practices, patient engagement, seamless care transitions, and capacity optimization.
- Organizational Governance Structure
  - Administrative Services
  - Budgeting/Financial Modeling
    - Clinical Model
    - Operational Model
    - IT CIO Needs
  - CIO Development Process will require multiple Workgroups, Task Forces, Structured Interface with The Medical Staff Leadership, etc.

- Organizational Infrastructure
- Network Development
- Clinically Integrated Organization (CIO)
- Care Delivery Transformation
- Payor Contract Restructuring

- Short Term
  Add sufficient size and scope to the delivery system to enhance its attractiveness to payors.
- Intermediate Term
  Collaborate with government, private payors, and employers to reward value and build accountability for managing healthcare quality/costs.
CIO Joint Venture Structure – Example

Ownership

CIO Wholly Owned By Health System or JV with Physicians

Contracting with
Payers for Care Management Fee and Physician Value-Based Performance Fee and Ultimately for “Single Signature” Agreements

Physicians

Members

0% - 50%
Physician LLC/With or Without PO

50% - 100%
HOSPITAL/HOSPITAL SYSTEM 501c3/LLC

Management Services

Physicians

HOSPITAL/HOSPITAL SYSTEM 501c3/LLC
Additional “Value-Based” Reimbursement Models – Example

FFS “Value-Based” Reimbursement Model

Payer/CMS → MEDICAL EXPENSES → Clinically Integrated Organization (CIO)

ADMIN COSTS

CARE MANAGEMENT FEES

$ Primary Care MDs
Key Specialists
Consulting Specialists
Hospitals
Ancillary Providers
Rx/Lab
Other

Fee-for-Service Schedule

VB Performance Payments

CLINICAL QUALITY TARGETS
PATIENT SATISFACTION TARGETS
RESOURCE UTILIZATION TARGETS

Targets Achieved
Value-Based (VB) Payment = FFS + Care Management and Shared Savings Fee Payment Combined - Example

CIO Value-Based Reimbursement

- ACO has 33 VBP metrics
- Some commercial-based products pushing towards 100 VBP metrics
- Medicaid will eventually migrate to VBP metrics (e.g., Ohio)

X% Physicians

$\ldots\ldots$ $\ldots\ldots$ $\ldots\ldots$ $\ldots\ldots$ $\ldots\ldots$

Shared Savings and Performance Bonuses from VB Payers

Y% Hospital

Specialist Groups

PCP Groups + Care PMPM Management Fees
## CIO Development Costs

<table>
<thead>
<tr>
<th>Development Activity</th>
<th>Description</th>
<th>Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physician Alignment Strategies</strong></td>
<td>Hospital Sponsored Medical Group Development; Co Management Specialty Entities, Service Line Bundled Payment; Medical Home</td>
<td>Varies as per alignment strategy—Often the most expensive part of the CIO</td>
</tr>
<tr>
<td><strong>Organizational development</strong></td>
<td>Planning, legal and other related services supporting development of organization and regulatory compliance</td>
<td>Legal and consulting support</td>
</tr>
<tr>
<td>CIO</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Payer contracting/Network Development</strong></td>
<td>Staffing support</td>
<td>Salary and Management Fees</td>
</tr>
<tr>
<td><strong>Care management</strong></td>
<td>Protocols, benchmarks, standards etc.</td>
<td>Licensing, software, personnel/navigators</td>
</tr>
<tr>
<td><strong>Informatics</strong></td>
<td>IT and HIE infrastructure</td>
<td>Hardware, software, licensing</td>
</tr>
<tr>
<td><strong>Health plan services/TPA</strong></td>
<td>Core health plan/TPA services-claims, financial tracking</td>
<td>To be provided by payer/TPA partner</td>
</tr>
<tr>
<td><strong>Physician education and training including Medical Staff Interface</strong></td>
<td>Development and transformation of clinical model and performance metrics</td>
<td>Compensation for modeling, development and other support</td>
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Clinical Integration Organization Formation Initiatives

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- Physician Organization” Project/Process
- “Medical Staff Collaboration” Project/Process

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- Engagement
- Structure for collaboration?
- Delegated Functionality

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Full Continuum of Care — Inpatient and Ambulatory Services Care Management

Phasing I – II – III

Three Out of the Four CIO Formation Projects Are Physician Centric
Driving Physician Engagement
- “Physician Organization” Centric Decisions Are Key

“Boots on the Ground “ Approach

Clinically Integrated Organization (CIO)

Physician Community
- Network Physicians
- Community Physicians (Not on Medical Staff)
- System Medical Staff

Network Physicians

Specialists

PCPs
“Physician Organization” Project/Process

CIO/ HOSPITAL VB INTEGRATED NETWORK

Shared Control

Board

Physician Umbrella Organization

Independent  Contracted  Employed

Physicians

Network Providers connected through protocols and technology

CIO Board and Committees

“All Things Clinical”
- Credentialing
- Peer Review
- Quality

Board Quality Committee/Clinical Governance Council

CIO Physician Representatives

Medical Staff Representatives*

* - Approved by Med Exec Committees at each hospital
“Physician Umbrella Organization” Project/Process: CIOs Start with Physician Organization Focus and Functions

- PUO serves as the organizing vehicle to facilitate and coordinate physician equity and governance participation in the CIO
- Key functions include:
  - Serving as vehicle for physician capital contributions and investment to the CIO
  - Selection of physician representatives on the CIO board
  - Determination of physicians’ positions on key policy issues, and transmission of those positions to the CIO physician board members
  - Enable expedited, 2-way communication with physicians
  - Education of physicians regarding advantages of participating in the PUO and the CIO
  - Recruitment of physicians to participate in the UO and the CIO
- The other role of the PUO is to support the Clinical Governance Council to hold membership accountable for clinical performance, e.g., ensure membership standards are upheld (credentialing) and quality targets are met
Driving Physician Engagement
– “Medical Staff Centric” Decisions Are Key

“Delegated Functionality “vs. “Delegated Authority”

Clinically Integrated Organization (CIO)

Network Physicians

Community Physicians Not on Medical Staff

System Medical Staff
Limitations of Medical Staff Existing Governance Structure

As health systems move toward tighter clinical integration, they need to fine-tune and expand the existing governance structure to solidify a more tightly integrated delivery system across the care continuum.

CORE PROBLEM

Hospital boards and management have limited authority to drive changes to practice patterns and policies to enable greater clinical quality, operational efficiency and effectiveness.

• Exacerbated by Joint Commission standard requiring medical staff approval before any medical staff by-law changes are made.
Fall 2010: Structure and Relationships – Case Study

- BOARD
  - Board Quality Committee
    - Central Division Physicians Council (PC)
      - Central Division Quality & Patient Safety Council
        - Operations Functions
          - Pharmacy and Therapeutics
          - Infection control
          - Accreditation
          - Patient Safety
          - Risk management
          - Other
MH Clinical Integration Vision – Case Study

Better Care for Individuals
- Independent Physicians
- Integrated Primary Care
- Integrated Specialty Care
- Integrated Care (Across Multiple Discipline's)

Better Care for Populations
- Mercy Health Physicians
- OUTPUTS
  - Wellness Programs
  - Medical Homes
  - Efficiencies
  - Cost Savings

Reducing Per Capita Costs
- Hospital-Based Physicians

TRIPLE AIM

INPUTS
- Quality Metrics
- Standardization
- Innovation
- Best Practices

NOTE: Adapted from existing Mercy Health slide
Discussion Slide: Campuses GAIN...

- Ability to have an influential voice in system clinical design and function
- A physician-led forum for addressing credentialing, peer review, and clinical quality from a system perspective
- Streamlined governance that will allow achievement of clinical excellence, maximize the patient experience, and improve physician satisfaction by reducing physician hassle and duplication of effort
- Ability to co-ordinate and integrate care across the system and be eligible for receiving value-based reimbursement
- Ability to share and aggregate physician clinical activity across all hospitals
CIO/Medical Staff Governance Collaboration - Case Study
“Start With the End in Mind”

SYSTEM BOARD

CEO

Executive Leadership

Board Quality Committee/CIC

System Credentialing
System Quality
System Peer Review

CIC Committees

Med Exec Committees
- MH Anderson Hospital
- MH Clermont Hospital
- MH Fairfield Hospital
- The Jewish Hospital
- MH Mt. Airy Hospital
- MH Western Hills Hosp.

Advisory Boards

Other Alignment Entities
- Mercy Health Select
- HealthSpan
- Mercy Health Physicians
- Senior Health & Housing
- Other Metro Entities
- Regional (CMHP/Others)

“CIC” focus is on identifying, recommending and monitoring clinical quality and safety objectives to enable “Meaningful Clinical Integration” and system-wide performance-based “single signature” risk contracting.
Driving Physician Engagement – “CIO Clinical Model” Transformation/Evolution Process

“CIO Clinical Model” = The Right Care At The Right Place At the Right Time and Emphasizes Care Mobility and Patient Stratification
MEDICAL HOME

Aligned network of specialists/ancillary providers/hospitals

Effective clinical care integration and coordination mechanisms

Flexible reimbursement models which support/reward high-value, cost-efficient services

Patient health information infrastructure including electronic health records, (EHRs), centralized data banks and benchmark performance reporting

QUALITY/FINANCIAL REPORTING

OUTCOMES/DATA/ANALYTICS
CIO/Patient Centered Medical Home/Care Coordination Model

**Patient Stratification**

- **Data Sources**
  - Claims
  - Rx
  - Lab
  - Referrals
  - Pt. Records
  - ER Admits
  - HRA

**Health Status Stratification**

- **High-Risk Patients** (Chronic disease unstable or changing / recently hospitalized)
- **Medium-Risk Patients** (Diagnosis unknown / chronic disease stable)
- **Low-Risk Patients** (Acute episodic care / routine health maint.)

**Clinical Management**

- **Patient Outcomes**
  - Routine preventive services
- **Clinical Pathways**
  - Intake
  - Triage for same day care

**Resource Management**

- **Provider Cost Analysis**
  - Predictive Modeling
- **Pay-for-Performance**
  - 1 Benchmarks

**CARE COORDINATION**

- Personal Physician
- Care Coordinator
- Allied Health Professionals

- **Episodic Outreach**
- **Episodic/Monthly Interventions**
- **Monthly / Weekly Interventions**
Examples of Potential Disease Management Frameworks

CIOs will need to develop the practice infrastructure necessary to manage chronic diseases more effectively and through that process improve better clinical outcomes.

At least three levels of complexity are necessary for a broad-based chronic disease management program.

<table>
<thead>
<tr>
<th>DM Target Example</th>
<th>Resources</th>
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<tbody>
<tr>
<td><strong>Site Level</strong></td>
<td>Diabetes</td>
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<tr>
<td><strong>MD Co-Management</strong></td>
<td>Dyslipidemia</td>
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<tr>
<td><strong>Across Continuum</strong></td>
<td>Heart Failure</td>
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</table>
ACOs – To Be Or Not To Be...
Snapshot of ACO’s

• **ACCOUNTABLE CARE ORGANIZATION**: A “state-specific” formal legal entity that would allow the organization to receive and distribute payments for shared savings to participating providers of services and suppliers via the Medicare Shared Savings Program

• Minimum eligibility requirements:
  – Legal structure and governance as required by MSSP final rules
  – Sufficient number of primary care physicians to have an assigned beneficiary population of at least 5,000 for a MSSP ACO

• Mandatory review from the antitrust enforcement agencies required only if ACO applicants fall outside of “safety zone” defined by final rule. However, if the ACO enters into “value-based” commercial products, special ACO specific antitrust exemptions must be re-reviewed

• **Multiple types of ACOs** – However, the Medicare Shared Saving Program ACO is the primary ACO model going forward with go live targets of April 2012, July 2012 and January 2013 including application deadlines approximately 3 months prior to go live dates. Two MSSP ACO models with different risk profiles.

• Other programs from the CMS Center for Innovation- Pioneer ACOs, Bundled Payments (Global Payment and/or Packaged Payment), Comprehensive Primary Care (PCP), etc.
ACO Building Blocks for Improved Care

- Patient and Caregiver Experience
- Care Coordination — Transitions
- Care Coordination — Information Systems
- Patient Safety

Improved Patient-Centered Care
TABLE 1 – MEASURES FOR USE IN ESTABLISHING QUALITY PERFORMANCE STANDARDS THAT ACOs MUST MEET FOR SHARED SAVINGS

<table>
<thead>
<tr>
<th>Domain</th>
<th>Measure title</th>
<th>NQF measure #/measure steward</th>
<th>Method of data submission</th>
<th>Pay for performance phase in R = Reporting</th>
<th>P = Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Patient/Caregiver Experience.</td>
<td>CAHPS: Getting Timely Care, Appointments, and Information.</td>
<td>NQF #5, AHRQ.</td>
<td>Survey ..................</td>
<td>R</td>
<td>P</td>
</tr>
<tr>
<td>5. Patient/Caregiver Experience.</td>
<td>CAHPS: Health Promotion and Education.</td>
<td>NQF #5, AHRQ.</td>
<td>Survey ..................</td>
<td>R</td>
<td>P</td>
</tr>
<tr>
<td>7. Patient/Caregiver Experience.</td>
<td>CAHPS: Health Status/Functional Status.</td>
<td>NQF #6, AHRQ.</td>
<td>Survey ..................</td>
<td>R</td>
<td>R</td>
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<tr>
<td>8. Care Coordination/Patient Safety.</td>
<td>Risk-Standardized, All Condition Readmission*.</td>
<td>NQF #7BD, CMS.</td>
<td>Claims ..................</td>
<td>R</td>
<td>R</td>
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<tr>
<td>10. Care Coordination/Patient Safety.</td>
<td>Ambulatory Sensitive Conditions Admissions: Congestive Heart Failure (AHRQ Prevention Quality Indicator (PQI) #8).</td>
<td>NQF #277, AHRQ.</td>
<td>Claims ..................</td>
<td>R</td>
<td>P</td>
</tr>
<tr>
<td>11. Care Coordination/Patient Safety.</td>
<td>Percent of PCPs who Successfully Qualify for an EHR Incentive Program Payment.</td>
<td>CMS ..................</td>
<td>EHR Incentive Program Reporting, GPRO Web interface.</td>
<td>R</td>
<td>P</td>
</tr>
<tr>
<td>13. Care Coordination/Patient Safety.</td>
<td>Falls: Screening for Fall Risk.</td>
<td>NQF #101, NCQA.</td>
<td>GPRO Web interface.</td>
<td>R</td>
<td>P</td>
</tr>
</tbody>
</table>
ACO Building Blocks for Improved Health

Preventive Health

Frail Elderly At-Risk Population

COPD At-Risk Population

Hypertension At-Risk Population

Improved Patient-Centered Health

Diabetes At-Risk Population

Heart Failure At-Risk Population

CAD At-Risk Population

At-Risk Population
<table>
<thead>
<tr>
<th>Domain</th>
<th>Measure title</th>
<th>NQF measure #/measure steward</th>
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<th>Pay for performance phase in Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>14. Preventive Health</td>
<td>Influenza Immunization</td>
<td>NQF #41 AMA–PCPI.</td>
<td>GPRO Web Interface.</td>
<td>R</td>
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<td>15. Preventive Health</td>
<td>Pneumococcal Vaccination</td>
<td>NQF #43 NCQA.</td>
<td>GPRO Web Interface.</td>
<td>R</td>
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<td>16. Preventive Health</td>
<td>Adult Weight Screening and Follow-up.</td>
<td>NQF #421 CMS.</td>
<td>GPRO Web Interface.</td>
<td>R</td>
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<td>17. Preventive Health</td>
<td>Tobacco Use Assessment and Tobacco Cessation</td>
<td>NQF #28 AMA–PCPI.</td>
<td>GPRO Web Interface.</td>
<td>R</td>
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<tr>
<td>18. Preventive Health</td>
<td>Depression Screening</td>
<td>NQF #418 CMS.</td>
<td>GPRO Web Interface.</td>
<td>R</td>
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<td>P</td>
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<td>19. Preventive Health</td>
<td>Colorectal Cancer Screening.</td>
<td>NQF #34 NCQA.</td>
<td>GPRO Web Interface.</td>
<td>R</td>
<td>R</td>
<td>P</td>
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<tr>
<td>20. Preventive Health</td>
<td>Mammography Screening</td>
<td>NQF #31 NCQA.</td>
<td>GPRO Web Interface.</td>
<td>R</td>
<td>R</td>
<td>P</td>
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<tr>
<td>21. Preventive Health</td>
<td>Proportion of Adults 18+ who had their Blood Pressure Measured within the preceding 2 years.</td>
<td>NQF #0729 MN Community Measurement</td>
<td>GPRO Web Interface.</td>
<td>R</td>
<td>P</td>
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</tbody>
</table>
### Table 1 – Measures for Use in Establishing Quality Performance Standards That ACOs Must Meet for Shared Savings

<table>
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<tr>
<th>Domain</th>
<th>Measure title</th>
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<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>31. At Risk Population—Coronary Artery Disease</td>
<td>Coronary Artery Disease (CAD) Composite: All or Nothing Scoring: Drug Therapy for Lowering LDL-Cholesterol.</td>
<td>NOF #74 CMS (composite)/ AMA–PCPI (individual component).</td>
<td>GPRO Web Interface.</td>
<td>R</td>
<td>R</td>
<td>P</td>
<td>P</td>
</tr>
<tr>
<td>32. At Risk Population—Coronary Artery Disease</td>
<td>Coronary Artery Disease (CAD) Composite: All or Nothing Scoring: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Patients with CAD and Diabetes and/or Left Ventricular Systolic Dysfunction (LVSD).</td>
<td>NOF #66 CMS (composite)/ AMA–PCPI (individual component).</td>
<td>GPRO Web Interface.</td>
<td>R</td>
<td>R</td>
<td>P</td>
<td>P</td>
</tr>
</tbody>
</table>

*We note that this measure has been under development and that finalization of this measure is contingent upon the availability of measures specifications before the establishment of the Shared Savings Program on January 1, 2012.*
Conclusion: Key ACO Considerations & Success Factors

1) Offensive and Defensive reasons for reconsideration of the MSSP ACO application process given new final rules (e.g., 3 year commitment by PCPs to one and only one MSSP ACO-Are your current Independent PCPs at risk of committing to another System/MSSP ACO without understanding the implications?)

2) Current healthcare enterprise strength in the local market

3) Relationship with existing Plans in market
   – Strength/barriers and ability to influence benefit design, reimbursement

4) System/hospital capacity to achieve consensus among MCI stakeholders re:
   – Approach to patient care
   – Performance measures
   – Compensation distribution
   – Risk accountability
   – Quality measures
   – Team based workforce (physicians, nurses, administrators)

5) Ability of system/hospital to influence selection of participating MCI network

6) Ability to deliver on selected core competencies in the practice setting
The Accelerated Push to Performance-Based Survival

**INCREMENTAL ADOPTION**

- Incremental legislative/ regulatory changes
- Technology/IT challenges
- Delivery system rationalization
- MD/Hospital interdependence accelerates

**STRATEGIC UNCERTAINTY**

- Patient Protection and Affordable Care Act 2010
- Delivery system size and market share
- Growing number of “uninsured”
- Physician/hospital and physician/physician aggregation/employment accelerates

**PERFORMANCE-BASED SURVIVAL**

- “Meaningful Clinical Integration”/“Value-Based" Payments/Physician Leadership/Engagement Roles begin to take center stage
- Optimizing physician/hospital partnering opportunities becomes paramount:
  - Hospital-sponsored medical groups/MD employment
  - Co-Management Agreements/Specialty CIOs
  - CIO/VBN/ACO/Medical Home
  - “Super CIOs” begin to form
Key Takeaways

**Building the Performance Driven Clinically Integrated Organization**

1) Physician Engagement and the Clinical Model — a balance of care delivery drivers, changing reimbursement and meeting growing a growing number of quality metrics/requirements — will drive everything.

2) Rigorous business planning and financial modeling must support the Health Plan/CMS payment methodologies.

3) Enterprise (physician/hospital entities) success factors inevitably include critical mass, clinical competency, physician leadership, system connectivity and active management of the transition to value-based reimbursement.

4) CIOs must be carefully developed and must be a separate legal entity that pass FTC regulations and Super CIOs must have the same “Meaningful Integration Functionality” as the CIOs. Antitrust Issues loom large for FFS clinical integration strategies especially because optimal models depend on data integration, reporting capabilities and ultimately a unified contracting capability.
Clinical Integration Investment and New Market Tax Credits

Types of Clinical Integration Investment

**Infrastructure**
- IT upgrades
- Patient navigators
- Clinical team support

**Physician Alignment**
- HSMG development
- Co-management
- Physician partnerships

**Facility**
- OR upgrades/expansion
- New or expanded MOB
- Outreach clinics

Federal government’s New Market Tax Credits can significantly reduce overall cost of clinical integration investment for qualified entities

- $36 billion program to drive economic growth in economically-challenged areas
- Represent significant source government-subsidized capital for 1,000+ qualified hospitals
  - NMTCs, hospital investments can qualify for 15-18% subsidy from federal government, significant reducing overall project cost
- Tapping NMTCs requires significant consulting, legal and accounting expertise to structure deal and access credits, the majority of which is paid once NMTC deal is closed
**Cost Reduction Opportunities - Today**

Each stakeholders significantly influences the cost of medical care and, likewise, can play a significant role in reducing costs.

<table>
<thead>
<tr>
<th><strong>Primary Care Physicians</strong></th>
<th><strong>Hospitals</strong></th>
<th><strong>Health Plans</strong></th>
<th><strong>Employers</strong></th>
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<tbody>
<tr>
<td>Health promotion</td>
<td>Unnecessary testing</td>
<td>Screening and early detection</td>
<td>Benefit design</td>
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<tr>
<td>Early diagnosis</td>
<td>Development of e-ICUs</td>
<td>Education and behavioral intervention</td>
<td>Consumer directed health plans</td>
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<tr>
<td>Unnecessary testing</td>
<td>Intensity of care level</td>
<td>Risk factor reduction</td>
<td>Health and wellness incentives</td>
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<tr>
<td>Unnecessary referral</td>
<td>Lowest cost treatment</td>
<td>Health promotion instruction</td>
<td>Health promotion</td>
</tr>
<tr>
<td>Preventable ER visits</td>
<td>Medical errors</td>
<td>Enrollment in diabetes prevention program</td>
<td>Value purchasing</td>
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<tr>
<td>Preventable admissions</td>
<td>Adverse advents</td>
<td>Benefit design incentives</td>
<td>Integrated health design</td>
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<tr>
<td>Preventable readmissions</td>
<td>Supply chain management</td>
<td>Generic drugs</td>
<td>Social networking for information</td>
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<tr>
<td>Care coordination</td>
<td>Physician outlier review</td>
<td>Network management</td>
<td>Include employees in design</td>
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<tr>
<td>Chronic care management</td>
<td>Staffing management</td>
<td>Multi-year contracting</td>
<td>Onsite clinics</td>
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<tr>
<td>Complimentary medicine treatment</td>
<td>Overhead reduction</td>
<td>Medical management</td>
<td>Onsite testing</td>
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<tr>
<td>Group visits</td>
<td>Implementing “real” connectivity</td>
<td>Chronic care coordination</td>
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<tr>
<td>E-visits</td>
<td>Use of navigators and advocates</td>
<td>Online social support</td>
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<td>Telemedicine visits</td>
<td>Hospital acquired infections</td>
<td>Cancer management as well as cure</td>
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<td>After-hours and weekend clinics</td>
<td>Preventable admissions</td>
<td>Remote patient monitoring</td>
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<td>Staffing urgent care as an alt to ERs</td>
<td>Preventable readmissions</td>
<td>E-visit reimbursement</td>
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<tr>
<td>Proctoring “minute clinics”</td>
<td>Preventable complications</td>
<td>In-home service</td>
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<tr>
<td>Specialist selection (most efficient)</td>
<td>Preventable ER visits</td>
<td>After-hours clinics (not ERs)</td>
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<tr>
<td>Practice efficiency</td>
<td>Preventable ancillary services</td>
<td>Hospitalists program</td>
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<td>Group practice design</td>
<td>Inpatient care efficiency</td>
<td>Integrated health management</td>
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<td>Pre-discharge planning</td>
<td>Claims process efficiency</td>
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<td>Post-discharge care management</td>
<td>Shared-risk arrangements</td>
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<td>Administrative efficiency</td>
<td>Performance-based reimbursement</td>
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<td>Pricing transparency</td>
<td>Health information technology</td>
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<td>Hospitalist programs</td>
<td>Information system efficiency</td>
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<td>Decision support software</td>
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<td>Technology assessment system</td>
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<td>Capital allocation</td>
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<td>Collaboration model</td>
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<td>Health promotion instruction</td>
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<td>Chronic care management</td>
<td>Benefit design incentives</td>
<td>Integrated health design</td>
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<td>Multi-speciality practice design</td>
<td>Generic drugs</td>
<td>Social networking for information</td>
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<td>Episode of care cost reduction</td>
<td>Network management</td>
<td>Include employees in design</td>
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<td>Discharge planning (reduce re-admission)</td>
<td>Multi-year contracting</td>
<td>Onsite clinics</td>
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<td>Pricing transparency</td>
<td>Medical management</td>
<td>Onsite testing</td>
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<tr>
<th><strong>Individuals</strong></th>
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<tr>
<td>Illness prevention</td>
<td>Screening and early detection</td>
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<td>Behavior modification</td>
<td>Education and behavioral intervention</td>
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<td>Self care</td>
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<td>Utilization rate</td>
<td>Health promotion instruction</td>
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<td>Comparison-shopping</td>
<td>Enrollment in diabetes prevention program</td>
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<td>After-hours clinics (not ERs)</td>
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**SSB Solutions**

AHA – CIO Discussion Document | March 2012

**PROPRIETARY AND CONFIDENTIAL**
### Performance-Based Financial Drivers for Health Systems

**VBP Model Redistributes Payments to Higher-Performing Hospitals**

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<tbody>
<tr>
<td>Market Basket (MB) Cuts for Productivity Adjustment (P) and Medicare Savings</td>
<td>MB-0.25</td>
<td>MB-0.25</td>
<td>MB-(P+0.1)</td>
<td>MB-(P+0.1)</td>
<td>MB-(P+0.3)</td>
<td>MB-(P+0.2)</td>
<td>MB-(P+0.2)</td>
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<tr>
<td>Reporting Hospital Quality Data for the Annual Payment Update Pay for reporting</td>
<td>MB-2.0 If Failure to Report</td>
<td>MB-2.0 If Failure to Report</td>
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<td>MB-2.0 If Failure to Report</td>
<td>MB-1/4 of MB If Failure to Report</td>
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<td>Hospital Value Based Purchasing</td>
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<td>Readmissions</td>
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<td>Hospital-Acquired Conditions</td>
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<td>Health Information Technology Meaningful Use (MU)</td>
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**Policies influencing Medicare DRG reimbursement levels (IPPS)**

Source: American Hospital Association analysis
Physicians (Especially PCPs) are Joining Hospital Sponsored Medical Groups and Becoming the Foundation for VB Narrow Network Plans

The “Medical Ecosystem & Hospital Sponsored Medical Groups”

Pressures on Physicians
- Declining payer reimbursement/growth in self-pay %
- Declining revenue from ancillaries
- PCP shortages
- Specialist Shortages
- Recruiting challenges
- Increased practice overhead
- Growing regulatory requirements

Pressures on Hospitals
- Pluralistic medical staff
- Declining payer reimbursement/Self Pay % grows
- Increased hospital quality/compliance requirements
- Physician-sponsored OP competition
- Increased consumer expectations
- Regulatory demands

The need to manage to Capacity & “Value-Based Payment” Align Physician and Hospital Interests

Value-Based Plans are optimized by HSMG/ Specialty Co Management Networks/CMS /Bundled Payment/CMS CMH, etc.
Specialty Focused Co-Management Structures Optimize Service Lines/Specialty CIOs In Both FFS and Value-Based Plan Environments

Hospital/Hospital System

Management Fee (FMV)
2-4% of Service Revenue

CO-Management / Specialty CIO LLC

Incentive fees based on achieving specified and measurable metrics for:
- Clinical quality
- Programmatic Expansion
- Operational goals
- CIO/ACOMSSP Requirements

Shareholder distributions made as available and sanctioned by LLC Board of Managers

Base Fees
- Operating expenses
- Admin Costs
- Medical Directors
- Boards and Committees

Incentive Fees
- Physician Investors
- Hospital Investors

$30% $70%
CIO/Healthcare Provider Services Organization (HPSO) – Expansive Example

“Master” provider services structure with a separate LLC or embedded structure to manage multiple reimbursement structures

- Can be a separate operating company or embedded
- Multiple potential structures
- Multiple levels of physician/hospital alignment
- Potential structure for “value based” ACO/medical home/bundled payment contracting
Meaningful Clinical Integration (MCI) vs. Economic Integration (EI) of Health Plan/CMS Products/Services between Physicians and Hospitals

Clinically Integrated Organization (CIO)
(e.g., VB Network, ACO, etc.)

"Meaningful Clinical Integration"
Fee-for-Service "Value-based"

Health Plan / CMS Reimbursement Methodology

Standard FFS Payment
(No MCI) (No EI)

"Value-Based" FFS Payment
(No EI)
- ACO (MCI 1+)*
- No ACO (MC 2+-4+)*

% Premium/ Capitation
(EI – No MCI required)

* 1+ MCI = Lower FTC MCI Threshold
   4+ MCI = Highest FTC MCI Threshold
## New Ways of Thinking and Working Under MCI/CIoTs

<table>
<thead>
<tr>
<th><strong>Old Clinical Model</strong></th>
<th><strong>New MCI Imperatives</strong></th>
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<tbody>
<tr>
<td>Insurance risk with payer</td>
<td>Performance risk/reward</td>
</tr>
<tr>
<td>Fight for share of revenue</td>
<td>Rational allocation of revenue</td>
</tr>
<tr>
<td>Charge based (FFS)</td>
<td>Value-based (performance = reward)</td>
</tr>
<tr>
<td>Physician dominant</td>
<td>Physician/patient directed</td>
</tr>
<tr>
<td>Get paid for quantity</td>
<td>Earn more for quality</td>
</tr>
<tr>
<td>Encounter focused</td>
<td>Episode of care and patient-centric</td>
</tr>
<tr>
<td>Split control and governance</td>
<td>Physician-championed governance</td>
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<tr>
<td>Do more</td>
<td>Do right thing at the right time</td>
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<tr>
<td>Reactive patient engagement</td>
<td>Proactive intervention</td>
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<tr>
<td>Clinical integration as legal step</td>
<td>Clinical integration for efficiencies and improved outcomes</td>
</tr>
<tr>
<td>Individual referral patterns</td>
<td>Referrals influenced by performance data and outcomes</td>
</tr>
<tr>
<td>Limited use of clinical IT</td>
<td>Active engagement and utilization of clinical IT</td>
</tr>
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Examples of Potential Disease Management Frameworks

CIOs will need to develop the practice infrastructure necessary to manage chronic diseases more effectively and through that process improve better clinical outcomes.

At least three levels of complexity are necessary for a broad-based chronic disease management program.

<table>
<thead>
<tr>
<th>DM Target Example</th>
<th>Resources</th>
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<tbody>
<tr>
<td><strong>Site Level</strong></td>
<td>Diabetes</td>
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<tr>
<td></td>
<td>Primary care</td>
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<tr>
<td><strong>MD Co-Management</strong></td>
<td>Dyslipidemia</td>
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<td>Primary Care Specialists</td>
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<tr>
<td><strong>Across Continuum</strong></td>
<td>Heart Failure</td>
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<td></td>
<td>Primary Care Specialists  Hospital</td>
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</tbody>
</table>
Site Level Disease Management Example: Diabetes

- Evidence-based guidelines/clinical decision support
- Patient registry

**CORE COMPONENTS**
- Designated care team devoted to diabetes management (“mid-level centric”)
- Standardized evidence-based guidelines re: testing and treatment
- Coordinated/systematic patient communication
- IT systems to support registry, data capture, patient communications, decision support and outcomes tracking
Physician Co-Management Example: Dyslipidemia

**CORE COMPONENTS**

- Two DM objectives:
  - Primary intervention
  - Secondary intervention

- Standardized evidence-based guidelines re: testing and treatment

- Standardized referral protocols

- IT systems to support registry, data capture, patient communications, decision support and outcomes tracking
Across Care Continuum Example: Heart Failure

CORE COMPONENTS

- Three DM objectives:
  - Primary intervention
  - Secondary intervention
  - Tertiary intervention

- Standardized evidence-based guidelines re: tracking and treatment

- Integration with hospital care pathways and case management programs

- IT systems to support registry, data capture, patient communications, decision support and outcomes tracking

Resource Intensity / Specialization

- Standardized referral protocols
- Evidence-based guidelines/clinical decision support
- Required patient data
- Timely and complete reports and records
- Patient registry

Chronic

Acute
Core Payer Strategies Support CIO Development

Recurrent Themes from Governmental Entities such as State Medicaid Programs and State Employee Programs (Plug and Play)

States are looking closely at programs and benefit structures to evaluate whether state funds go to Health Plans or Delivery System CIOs. Such as:

- Texas incentivizing the aggregation of multiple rural hospitals to form a 14 hospital CIO to contract for Texas Medicaid and Dual Eligible Beneficiaries;
- New York Medicaid going to a “North Shore Long Island Hospital/ValueOptions” partnership for coordinated mental health benefits;
- Arizona looking at Super CIOs consisting of Multiple Health System CIOs coming together to form an entity to compete against health plans or larger delivery system CIO competition; and
- Nebraska contracting with United Health Plans for State employees at the expense of BCBS of Nebraska.
Core Payer Strategies Support CIO Development

Recurrent Themes from Large For Profit Health Plans

• United, Humana, Aetna, and Cigna are launching or will launch “Value-Based Plans” (VPNs) starting with existing core products: 1) ASO Employer Plans (CIGNA), 2) Medicare Plans (Humana, United); 3) Small, Mid Size and Large Group Employer Plans (United, Aetna, etc.); 4) Individual Market/State Exchanges (United, Aetna, Cigna, Humana, etc.) and Medicaid (United, Aetna, Cigna, Humana). All want dual eligibles due to their high cost. Select companies want Medicaid.

• Every major plan views VBP as creating a lower price point option and very attractive to the employer and with or without retail (Exchange) markets.

• Virtually all for profit plans see VBP leading to more at risk/ % of premium contracting with narrower networks.

• Health plans will employ providers of all types especially PCP’s.
Core Payer Strategies Support CIO Development

Cigna
- 80% of Current Business is ASO primarily for National Accounts they see that core competency moving to VBP products administered through State Based Exchanges.
- They view that ASO capability as what CIOs providing VBP products will need.
- Migrate existing ASO EE’s to Medicare Plans and enter Medicare Plan arena (1.4 million potential members)
- Cigna is using the term “ASO” the way other plans are using VBP infrastructure
- Concentration in “Go Deep Markets” with “Platinum Narrow Networks
- Healthspring acquisition consistent with VBP

Aetna
- Wants to eliminate email this year go entirely to social media and consumer/business based apps (acquired iTriage and has 3-4 million apps sold)
- Major Products will be: Medicare, State Based/Retail Exchange Products; Existing Core Employer Based Products
- Big investments in CIO/ACO infrastructure including Medicity for data management VBP capabilities
- Banner Relationship is emblematic: Banner in PHX gave Aetna “significant discounts- low double digits” to create a VBP with a low price point (potentially for exchange or EE offerings)

Humana
- Large Medicare Advantage Presence today which they feel will optimize ACO VBP capabilities in the future for many additional products: State Insurance Exchange, Medicaid where it makes sense, etc.
- 15% Rule- VBP products (Medicare or other payment methodologies) should have at least a 15% cost advantage over competitor products.
- Ultimately Humana earns 10% for payer provided infrastructure and 5% goes to Humana Shareholders
Investment in CI infrastructure and workflow redesign lead to increased costs in short-term such as:

- Physician Alignment Strategy
- CIO Administrative Infrastructure Development
- Clinical Model Transformation
- Physician Organization/Network Creation
- Medical Staff/CIO Collaboration

Revenues and expenses per enrollees
Over time, overall cost of care decreases dramatically due to increased care efficiencies, population management and increased quality of care. This effect occurs due to:

- Physician Alignment Structures Mature
- CIO Administrative Model Developed
- Physician Organization/Network Evolution
- Medical Staff/CIO Collaboration Occurs

Aggregate cost of care is now between Medicaid and Medicare levels
Super Clinical Integration Organization (Super CIO) Maybe Necessary When One CIO Does Not Have Adequate Mass

- CIO #1 Hospitals
- CIO #1 participating physicians
- CIO #1 Co-mgmt. Companies
- Other entities focused on clinical integration/performance

- CIO #2 Hospitals
- CIO #2 participating physicians
- CIO Co-mgmt. Companies
- Other entities focused on clinical integration/performance

- CIO #3 Hospitals
- CIO #3 participating physicians
- CIO Co-mgmt. companies
- Other entities focused on clinical integration/performance

SUPER CIO
Performance Standards
Provider Network Support
Support Infrastructure
Other Duties and Responsibilities

Payers
Contracts
Revenue

Organization 3

Organization 4

Contracted Services
- Enterprise, Site Specific, Specialty, etc.