Managed Care Contracting

Greater Kansas City MGMA- April 22, 2015
Health Care Reform - Starting off on a Serious Note

- Who is the real victim?

- http://pol.moveon.org/insurance_execs/?&reloaded=1
Objectives of the Presentation - Attendees will:

1. Better understand the basics of payor performance analysis and the impact on your bottom line
2. Take a strategic view of contracting and negotiations and positioning for volume and profit
3. Review negotiation strategies that work and have a better understanding of the payors psychology
4. Understand the differences between fee for service, value based purchasing and risk share and differences in negotiations to consider
5. Better understand ACO’s, characteristics, prevalence, opportunities and challenges.
6. Better understand the Exchange and how it may impact your contracting strategy
7. Challenged to consider the future of healthcare reform and how it may impact your business and clinical practice into the years to come
Objective #1

- Better understand the basics of payor performance analysis and the impact on your bottom line
Getting Started (establish a baseline - get organized)

- Obtain all contracts and fee schedules
- Baseline of Payments
- Performance by Payor
- Payor mix
- Fee schedule reviews
- Negotiate with data
The Basics of All Contract Review -
Know who you are dealing with

- Who is the Payor
- What is their motive
- Who are they aligned with
- Do they have a good reputation
- What volume do they represent to you
- Are they willing to truly partner with you to provide added steerage
- What are “their” plans for the future? Does it coincide with yours?
Inventory your Contracts and Fee Schedules

- Collect and organize all of your contracts and fee schedules - keep electron ideally
- Inventory the contract terms to ascertain certain key contract provisions
  - Effective Dates
  - Term
  - Termination Provisions
  - Material Changes
  - Claim submission
  - Appeal deadlines
  - Assignment Provisions
Here is a Novel thought

- Know how much you need to be paid to cover your expenses now and into the future. Does a fee schedule that pays 100% of Medicare cover your costs?

- Know what your contracts say about important things like:
  - Can they change the rates on you?
  - Can they assign the contract to another payor?
  - Will they pay you for all of your services or have they carved some services out?
  - What products can they use this contract for? (Medicare, Medicaid, Exchange)?
What is wrong with this language?

- **Material Changes** - Payor will notify Physician 30 days prior to any material changes.

- **Amendment** - Both parties must mutually agree in writing to any amendment to the contract, however notwithstanding the above, the Payor can amend the contract at any time with a 30 day notice to the Physician.

- **Assignment** - Both parties must mutually agree in writing to any assignment of the contract, however Payor may assign the contract to any of its affiliates at any time with a 30 day notice to Provider.

- This contract may not cover some services as noted below:
Review the basics of payor performance analysis

- Total Revenue
- Reimbursement + patient payment (allowable)
- Percentage (Reimbursement to Charges)
- Percentage of Total Revenue
- Services Below Cost (Do you know your cost to charge ratio)?
All Payors
% Total Gross Revenue

- BLUE CROSS 25%
- All Other Commercial 11%
- Medicare (incl MCR Mngd Care) 52%
- Medicaid (incl KanCare, MCID) 7%
- All Other 5%
Commercial Payors Only
% of Comm'l Total Gross Revenue

- BLUE CROSS 70%
- Coventry (First Health PHS/Cov/HCPref) 6%
- Other Comm'l (Prf Health, WPPA, Century, UHC) 2%
- HPK (Aetna, Cigna, Humana) 12%
- CHCS INSURANCE (WPPA) 7%
- Commercial Insurance 3%
Example

<table>
<thead>
<tr>
<th>2013 (12 months data)</th>
<th>Charges</th>
<th>% of total Rev</th>
<th>Payments</th>
<th>% of total Payments</th>
<th>Cost to Charge ratio is 39%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial Insurance #1</td>
<td>$242,904.00</td>
<td>13.2%</td>
<td>$99,279.27</td>
<td>40.9%</td>
<td>2% margin</td>
</tr>
<tr>
<td>Commercial Insurance #2</td>
<td>$1,152,245.00</td>
<td>62.7%</td>
<td>$425,793.00</td>
<td>37.0%</td>
<td>2% loss</td>
</tr>
<tr>
<td>Medicare</td>
<td>$308,907.00</td>
<td>16.8%</td>
<td>$95,722.00</td>
<td>31.0%</td>
<td>8% loss</td>
</tr>
<tr>
<td>Medicaid</td>
<td>$134,874.00</td>
<td>7.3%</td>
<td>$34,722.00</td>
<td>25.7%</td>
<td>14% loss</td>
</tr>
<tr>
<td>Total</td>
<td>$1,838,930.00</td>
<td></td>
<td>$655,516.27</td>
<td>35.6%</td>
<td>&gt; 4% loss</td>
</tr>
<tr>
<td>Code</td>
<td>Place of Service (Facility or Office)</td>
<td>Charges</td>
<td>Total Volumes</td>
<td>Charges X Volume</td>
<td>Medicare 2014 locale 02</td>
</tr>
<tr>
<td>---------</td>
<td>--------------------------------------</td>
<td>---------</td>
<td>---------------</td>
<td>------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>99203</td>
<td>office</td>
<td>$150.00</td>
<td>1008</td>
<td>$151,200.00</td>
<td>$106.31</td>
</tr>
<tr>
<td>99204</td>
<td>office</td>
<td>$230.00</td>
<td>236</td>
<td>$54,280.00</td>
<td>$163.88</td>
</tr>
<tr>
<td>99213</td>
<td>office</td>
<td>$105.00</td>
<td>1306</td>
<td>$137,130.00</td>
<td>$71.72</td>
</tr>
<tr>
<td>99214</td>
<td>office</td>
<td>$160.00</td>
<td>383</td>
<td>$61,280.00</td>
<td>$105.91</td>
</tr>
<tr>
<td>99215</td>
<td>office</td>
<td>$230.00</td>
<td>66</td>
<td>$15,180.00</td>
<td>$141.95</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$1,387,295.00</td>
<td></td>
</tr>
<tr>
<td>% Charges</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>21%</td>
</tr>
<tr>
<td>Medicare as a % of Charges</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metric</td>
<td>Payor #1</td>
<td>Payor #2</td>
<td>Payor #3</td>
<td>Payor #4</td>
<td></td>
</tr>
<tr>
<td>-----------------</td>
<td>----------</td>
<td>----------</td>
<td>----------</td>
<td>----------</td>
<td></td>
</tr>
<tr>
<td>% billed charges</td>
<td>25%</td>
<td>50%</td>
<td>45%</td>
<td>18%</td>
<td></td>
</tr>
<tr>
<td>% of 2014 Medicare</td>
<td>121%</td>
<td>139%</td>
<td>130%</td>
<td>87%</td>
<td></td>
</tr>
<tr>
<td>Margin</td>
<td>0</td>
<td>25%</td>
<td>20%</td>
<td>-7%</td>
<td></td>
</tr>
</tbody>
</table>
Compare Fee Schedules by Top Codes and Volumes

- Compare the overall to a benchmark, i.e. Medicare
- Calculate the expected % of total charges
- Calculate the expected % of Medicare
- Compare to your cost to charge ratio
- Evaluate fee schedules for specific codes of concern
- Review expected to what you are collecting - look for disparity (red flags)
Project Impact of Renegotiations

- Use current data to project impact of a % increase in the current fee schedule or
- Use current data to project impact of a % increase that equates to current Medicare
- Consider sustainability of current and proposed rates and/or escalators going forward
- Will the escalators keep pace with your costs?
- When will you need to renegotiate again?
<table>
<thead>
<tr>
<th>Code</th>
<th>Place of Service (Facility or Office)</th>
<th>Charges</th>
<th>Total Volumes</th>
<th>Medicare 2013 locale 02</th>
<th>Charges with Volumes</th>
<th>Medicare with Volumes</th>
<th>Payor #1</th>
<th>Volume Impact</th>
<th>Proposed Rate Payor #1</th>
</tr>
</thead>
<tbody>
<tr>
<td>99203</td>
<td>office</td>
<td>$150.00</td>
<td>1008</td>
<td>$106.71</td>
<td>$151,200.00</td>
<td>$107,563.68</td>
<td>$103.84</td>
<td>$104,670.72</td>
<td>$122.72</td>
</tr>
<tr>
<td>99204</td>
<td>office</td>
<td>$230.00</td>
<td>236</td>
<td>$163.01</td>
<td>$54,280.00</td>
<td>$38,470.36</td>
<td>$159.19</td>
<td>$37,568.84</td>
<td>$187.46</td>
</tr>
<tr>
<td>99215</td>
<td>office</td>
<td>$230.00</td>
<td>66</td>
<td>$140.89</td>
<td>$15,180.00</td>
<td>$9,298.74</td>
<td>$138.03</td>
<td>$9,109.98</td>
<td>$162.02</td>
</tr>
<tr>
<td>44206</td>
<td>facility</td>
<td>$2,700.00</td>
<td>8</td>
<td>$1,793.68</td>
<td>$21,600.00</td>
<td>$14,349.44</td>
<td>$1,684.39</td>
<td>$13,475.12</td>
<td>$2,062.73</td>
</tr>
<tr>
<td>46260</td>
<td>facility</td>
<td>$725.00</td>
<td>49</td>
<td>$483.93</td>
<td>$35,525.00</td>
<td>$23,712.57</td>
<td>$533.78</td>
<td>$26,155.22</td>
<td>$556.52</td>
</tr>
<tr>
<td>44210</td>
<td>facility</td>
<td>$2,700.00</td>
<td>2</td>
<td>$1,835.23</td>
<td>$5,400.00</td>
<td>$3,670.46</td>
<td>$1,718.94</td>
<td>$3,437.88</td>
<td>$2,110.51</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Charges as a % of Medicare</th>
<th>144%</th>
<th>Allowable as a % of Charges</th>
<th>69%</th>
<th>80%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare as a % of Charges</td>
<td>70%</td>
<td>Allowable as a % of Medicare</td>
<td>99%</td>
<td>115%</td>
</tr>
</tbody>
</table>

**Expected Increase** $32,207.23
Other Considerations

- Days in AR
- Dollars denied and not overturned on appeal
- Administrative hassle factor
- Political reasons to contract
- Consider the future - lock out for future products?
- Acquisitions and mergers
- Government Products (Medicare, Medicaid, Exchanges)
Monitor and Validate

- Days in AR - interest penalties
- Underpayments
- Recoups
- Denials
- Calendar (time to renegotiation - meet with payors 1X per year)
- Summary tracking
VERY IMPORTANT

• READ EVERY LETTER YOU GET FROM A PAYOR

• RESPOND TIMELY IF THEY ARE CHANGING THE RATES OR THE WAY THEY PAY YOU

• ASK QUESTIONS IF THE LETTER IS NOT CLEAR

• “We are so happy to announce that we now going to pay you 50% of what you originally contracted for. If we don’t hear from you, we assume you are agreeing to this change”
Objective #2

- Take a strategic view of contracting and negotiations and positioning for the volume and profit
Take a strategic view of contracting and negotiations

• If you lost a contract that reduced revenue, would you in turn be able to reduce overhead and reduce costs in response?

• If you lost revenue from a lower paying contract, can you make it up from more volume on a higher paying contract?

• What is the competitive environment— who do you compete with now and who might you compete with in the future?

• Are you considering adding new services or additional providers?

• What is the situation of your practice?
  • At capacity - don’t need new volume
  • Need volume to cover overhead
## Example - Changing Payor Mix

<table>
<thead>
<tr>
<th>Payor</th>
<th>Total Rev (Charges)</th>
<th>Reimbursement (Insurance + Pt Responsibility) collected</th>
<th>% (Reimb to Charges)</th>
<th>Current Contracted Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>NOW</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Payor #1</td>
<td>18,205,690.00</td>
<td>8,738,731.20</td>
<td>48%</td>
<td>100% Medicare</td>
</tr>
<tr>
<td>Payor #2</td>
<td>1,600,828.00</td>
<td>1,248,645.84</td>
<td>78%</td>
<td>120% of Medicare</td>
</tr>
<tr>
<td>Total</td>
<td>19,806,518.00</td>
<td>9,987,377.04</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>After 10% conversion</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Payor #1</td>
<td>16,385,121.00</td>
<td>7,864,858.08</td>
<td>48%</td>
<td>100% Medicare</td>
</tr>
<tr>
<td>Payor #2 (renegot old bus)</td>
<td>1,600,828.00</td>
<td>1,280,662.40</td>
<td>80%</td>
<td>140% Medicare</td>
</tr>
<tr>
<td>Payor #2 (new bus)</td>
<td>1,820,569.00</td>
<td>1,092,341.40</td>
<td>60%</td>
<td>130% of Medicare</td>
</tr>
<tr>
<td>Total</td>
<td>19,806,518.00</td>
<td>10,237,861.88</td>
<td>52%</td>
<td>250,484.84</td>
</tr>
</tbody>
</table>
Objective #3

- Review negotiation strategies that work and have a better understanding of the payors psychology
Strategic and Effective Negotiations

• Much in the literature - what I have found to work

• Do your homework - know what you are being paid, how you are being treated and “your specific market”

• Look around the corner and what might be coming in the next few year (mergers, government plans, exchanges, risk shares, ACO’s, narrow networks)

• Don’t be afraid to ask for what you want

• Frame your request with reasons why you are asking for a certain rate - know your quality and efficiency scores and reasons the payor needs you (special services or protocols)

• Make sure your physicians are on board and understand that termination may be a real possibility if you are not successful.
Share Blind data with the Payors to Prove Your Point

Current Rates as % 2014 CMS

- 50%
- 109%
- 119%
- 126%
- 136%
- 140%
Strategic and Effective Negotiations - Continued

- Don’t cave too quickly
- Don’t make the first offer
- Think positive
- Think about the best and worst outcome
- Read the fine print - methodologies of payment, easy to overlook definitions etc...
- Be transparent and share data to prove your point
- Check the literature on the company - high profits and pay for CEO’s etc...
Just for Fun

- Aetna CEO made $30.7 million in 2013 - 131% increase from 2012

- According to Health Plan Week, a trade publication, the CEOs of the 11 largest for-profit companies were rewarded with compensation packages last year totaling more than $125 million.

- Centene’s CEO salary increased from $8.5 million to $14.5 million (Medicaid)

- Molina’s CEO salary jumped from $4.95 million to $11.9 million (Medicaid)
Strategic and Effective Negotiations - Continued

- Don’t be afraid to escalate to a higher lever
- Don’t give up on what you want - be tenacious
- Be willing to give up lesser things to get better rates on more important services
- Think about your service line and what might be growing in the future
- Don’t let the payors intimidate you - some will try
Strategic and Effective Negotiations - Continued

- Use Silence and Time as a tactic
- Be willing to walk away
- Don’t take it personally - enjoy the payor representative and let them know they are appreciated
- Finally be honest and as transparent as possible
- Don’t share confidential data from other contracts
- Don’t violate antitrust by sharing confidential data with your peers for negotiation purposes (not worth it)
Objective #4

- Understand the differences between fee for service, value based purchasing and risk share and differences in negotiations to consider
So What does Burwell, Secretary of HHS have to say about the future?

- [https://www.youtube.com/watch?v=UY088YyQ6uA](https://www.youtube.com/watch?v=UY088YyQ6uA)

- 30 percent of all fee-for-service payments to providers will convert to quality initiatives through alternative payment models by 2016, and 50 percent by 2018,

- Bundled Payments - Alternative Source of Payment to reduce cost and increase quality
Doc Fix - Obama expected to sign

- The bill would repeal the current Medicare payment formula for doctors and replace it with one that would increase payments to doctors by one-half of 1% every year through 2019. After that, doctors would receive bonuses or penalties depending on performance scores from the government. Their scores would be based on the value of the care they provide rather than on the volume of patients they see.

- Without a fix, physicians payment by Medicare would be reduced 21%
The Realities of Accountable Care

- IOM estimates $765 B in Waste (in our healthcare system)
- Healthcare costs for a Typical Family of Four has increased from $16,771 - $22,030 (31% over the last 5 years)
- All components of medical care are increasing with outpatient being the fastest to grow at 9.2% - this has not however decreased the growth of inpatient costs
- Healthcare providers are paid FFS and are not incentivized to coordinate and reduce care (when appropriate)
- We cannot afford to stay on this track
Physicians - Central to Reform

- Estimates indicate 56% of total Medicare expenditures relate to items physicians order or control, while roughly 10% is on the physician professional component

- (source: Seminar held by the Center for Healthcare Quality and Payment Reform)
Value Based Purchasing

- Capitation
- Bundled Payments
- Episodic Payment
- Pay for quality, not volume
- Steerage and bonuses will go to high quality and low cost providers
- If you use a high cost hospital, you could end up being hurt
- ACO’s and other CINS (clinically integrated networks) of providers
Common Metrics (Paid a PMPM or % Shared Savings if achieved)

- Generic Dispensing Rate
- 30 Day readmission rate
- Breast Screening
- Colorectal Cancer Screening
- Hemoglobin A1C testing (A1c level > 9 %)
- Appropriate testing for children with pharyngitis
- Avoid ER Encounters use per 1,000 members)
- RX Compliance (medication adherence)
- High risk medication review in elderly
- Comprehensive Adult Diabetic Care -
  - cholesterol screening
  - Cardiovascular care - cholesterol screening
  - Cervical Cancer Screening
  - Diabetes Care - LDL-C Level < 100 mg/dL (CDC)
  - Diabetic Treatment Measure
  - ACEI or ARB as recommended Use of disease management programs
  - Follow up visit within two weeks of discharge
  - Prevental IP Admissions (noted below)  Adult asthma  Bacterial Pneumonia  CHF  COPD  Dehydration  Kidney Urinary Tract Infection
<table>
<thead>
<tr>
<th>Payment Incentive Methodology</th>
<th>Payor #1</th>
<th>Payor #2</th>
<th>Payor #3</th>
<th>Payor #4</th>
<th>Payor #5</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Example (Quality Reimbursement)</em></td>
<td>$100/exam plus upside risk share</td>
<td>Coordination of Care Fee plus upside risk share</td>
<td>$8.25 PMPM plus upside risk share plus $160/exam</td>
<td>Annual $100 - $180 per member incentive (compliance in metric areas)</td>
<td></td>
</tr>
<tr>
<td># Members</td>
<td>NA</td>
<td>500</td>
<td>100</td>
<td>800</td>
<td>Varies (based on metric category) See above</td>
</tr>
<tr>
<td>Metric base (Annual reimbursement prior to increase)</td>
<td>$365,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% or PMPM increase (Quality incentive max)</td>
<td>4%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td># Months or annual (as applicable)</td>
<td>12</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sub Total (Quality Incentive)</td>
<td>$14,600</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comprehensive Exam</td>
<td>$100</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td># Member Months or members (as applicable)</td>
<td>500</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sub Total (Exam)</td>
<td>50000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shared Savings (Assumptions made based information from the Health Plan)</td>
<td>$10.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td># Member Months or members (as applicable)</td>
<td>6000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sub Total (Shared Savings)</td>
<td>$60,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>$14,600</td>
<td>$110,000</td>
<td>$60,000</td>
<td>$288,970</td>
<td>$136,800</td>
</tr>
</tbody>
</table>
Changes in Revenue

- Revenue is limited - increasing rates paid to providers is slowing and will stop in most cases - moving from fee for service to other forms of payment
  - Capitation
  - Bundled payments (pay for episodes of care includes all providers)
  - Percentage of Premium

- Increase rates by improving quality and efficiencies

- Put processes in place to capture revenue from wellness and health risk assessments and follow-up visits after ER or hospital discharges

- Revenue will shift to the provider taking the risk and controlling the care - who is in a better position than the physician?
Changes in Revenue - continued

- Document the complexity of the patient and you increase the potential for additional per member per month reimbursement (Medicare)

- Hospitals stand to lose the most through decreased volumes - that is why they want in the game to limit their losses

- Predict more care given in ASC’s, Specialty Hospitals, Diagnostic Labs, Urgent Care Centers, Birthing Centers

- Predict more carve outs to national laboratories and select ancillary groups with a national presence

- Predict narrow networks - contracting with providers that can prove quality and are willing to participate in managed care models
Where will the extra money come from?

- Proving Quality
- Reducing the cost of care at setting where there is money to be saved
  - Hospital versus ASC
  - Hospital versus Diagnostic Labs
  - Hospital versus Urgent Care
  - Hospitals versus Birthing Centers
  - Readmissions
  - Evidence based medicine (reduction of unnecessary testing and treatment)
- Physicians versus mid-levels
- Keeping people at home and out of nursing homes
What is happening in the hospital will affect you

- Medicare penalties for readmissions within 30 days (Heart Attack, pneumonia, hip or knee surgery) increased penalty from 2% to 3% on DRG payments

- Hospital Value-Based purchasing program - CMS took back 1.25% of Medicare reimbursement at hospitals paid under IPPS in 2014. Healthcare quality (heart attack, CHF patient satisfaction)

- Hospital acquired conditions - reduce reimbursement 1%

Source - CMS 2015 IPPS Final Rule: 7 things to know - Beckers report
What to Expect (Impact on your Practice)

• Relationship with Payors - New forms of payment
  • Shared Risk contract (read the fine print and know your measures and targeted MLR)
  • Pay for Performance (quality and efficiency)

• Data and analytics (IT solutions)
  • Establish a baseline (obtain payor and EMR data)
  • Set goals for individual and population management
  • Assist providers in monitoring and coordinating care tied to best practice
  • Confirm and validate improvements (as per payor contracts)
What to Expect (Impact on your Practice - continued)

- New Processes (To use the data and manage the care more proactively)
  - Care Coordination (individuals and groups with similar conditions)
  - 360 degree view of the patient (treat the whole not the part)
  - Changes the physician visit (proactive, longer term, holistic)
  - Engage the patients to take responsibility for their own health

- Greater communications (with other providers and payors)
  - Hospitals (admissions, ER use)
  - Specialists and other sources of care (Health Departments)
  - Health Information Exchange (LACIE and KHIN)
  - Gaps in care uncovered through claims process (wellness exams)
  - Patients at high risk for ER, Admissions etc...
Know the historical MLR

<table>
<thead>
<tr>
<th>Medical Loss Ratio</th>
</tr>
</thead>
</table>
| 90%                | Share 5% COST  
| 85% Target         |  
| 80%                | Share 5% Savings  

Only If you also achieve quality targets
Negotiate the Quality Targets

- Pick targets you know you can achieve
- Pick targets that you know you can track and validate (prove)
- Pick targets that coincide with other contracts
- Pick targets into the next 3 years (term of contract)
Risk Shares

• If you feel certain that you will reach the quality and MLR targets, take the full risk - why share the savings?

• The first year theoretically should be the easiest to be successful IF you have processes in place to track your progress

• Make sure you have processes in place that coincide with the risk share opportunities
The complexity of data requires you put systems in place to work intelligently

- Patient registries for organizing and tracking data and ease in communication between providers and with patients
- Aggregated date for analytics and research
- Care Coordination on both acute and chronic conditions
- Population management (planning and tracking of progress)
- Transitions of Care and sharing of alerts and data around ER and Admissions
- Communicate discharges between hospitals and clinics.
- Enhance operations and cost efficiencies through a suite of operational and cost metrics
Populations Management - Value Based Purchasing

- Extract, normalize and submit CMS Quality Measures and Meaningful use
- PCMH and Care Coordination Efforts - Patient Registry
- Transitions of Care - Reduce Readmissions
- Avoiding Unnecessary Admissions and Services - Reduce Cost and Increase Quality
- Creating Opportunities for Community Collaboration - Asthma Ready Program with School Systems - taking it to the next level
The Transition of Care Application will have the following registries:

- Admit
- Discharge
- Ready to Bill

The ToC App will also include Billing to CMS functionalities increasing efficiency of billing process.

Client’s staff will be able to manually input data and mark electronic forms submitted via fax services.

Data will be harvested:
- directly from hospitals via ADT data feeds
- from fax servers

Workflow will gain the following benefits from using the SQI Platform and Applications:

- Enhanced efficiency of data flows and automation
- Increased effectiveness of working with patients
- Fully HIPAA-compliant solution
- Have a process that scales
Source: Identifying and Quantifying the Cost of Uncoordinated Care: Opportunities for Savings and Improved Outcomes, Mary Kay Owens, R.Ph., C.Ph, Institute of Medicine, 2009.
Objective #5

1. Better understand ACO’s, characteristics, prevalence, opportunities and challenges.
2. Accountable Care Organization - is as the name implies
3. Many forms and structures
4. He who has the contract, controls the money flow
5. May cause conflict between provider groups
6. Will ultimately reduce utilization
7. Those with the greatest waste, lack of coordination and communications and processes have the greatest opportunity for success
Characteristics

1. Accountable Care Organization - is as the name implies
2. Many forms and structures
3. He who has the contract, controls the money flow
4. May cause conflict between provider groups
5. Will ultimately reduce utilization
6. Those with the greatest waste, lack of coordination and communications and processes have the greatest opportunity for success
What are the various types of ACO’s? (If you have seen one - you have seen one!)

- Governmental (Pioneer, Medicare Shared Savings Program, Bundled Payments for Care Improvement Initiative, Physician Group Practice Demonstration Program, Advance Payment Model - rural providers, State-wide Medicaid - Health Homes)

- Commercial (Aetna, BCBS, United, Cigna, Humana) New announcements daily - April 2014 - announced 15 new Private Sector ACO’s (Texas, New Jersey, Connecticut, Iowa, Missouri, Florida, Ohio, California)
Total Public and Private Accountable Care Organizations, 2011 to January 2015
Source: Leavitt Partners Center for Accountable Care Intelligence
Number of ACOs by State, January 2015
Source: Leavitt Partners Center for Accountable Care Intelligence
Estimated Percent of Population Covered by an ACO, by State, January 2015
Source: Leavitt Partners Center for Accountable Care Intelligence
Number of ACO Covered Lives, 2011 to January 2015
Source: Leavitt Partners Center for Accountable Care Intelligence
Number of ACO Contracts
Source: Leavitt Partners Center for Accountable Care Intelligence
Estimated Future Growth of Lives Covered by ACO’s  
Source: Authors Analysis
Characteristics of Different ACO’s

- Shared risk (Upside only and Full)
- Pay for Performance out of savings (not at risk)
- Withholds paid only if P4P is met (quality and cost)
- Percentage of Premium (full risk)
- Medical cost budgets and Medical Loss Ratio
- Bundled (paying for an episode of care)
- Capitation (form of full risk)
  - Can be for all services or a select scope of services
Forms of payment

- Continued mix of contracting models depending on locations and density of population
- Accountable Care (Coordination of care)
- Bundled services
- Episodic Care
- Pay for performance
- Percentage of Premium - capitation
- Direct Contracting
- Expanded use of the Electronic Medical Record
What does this mean for the future?

- Data transfer
- Clinical and/or Financial Integration
- Population Health Management
- Focus on Health Home
- Patient involvement and engagement
- Further standardization - Evidence Based Medicine
- Greater Coordination of Care
What will this mean for the future?

- Wellness, preventative health care, whole body (mental and physical)
- Government expansion (Medicare and Medicaid)
- Standardization - Evidence Based Medicine - Decreasing variances
- Greater coordination of Care
- Baby Boomers hitting Medicare - Increase in volumes
So far so Good  (2014 CMS Report)

- Medicare ACOs continue to succeed in improving care, lowering cost growth *(Updated November 7, 2014)*

- *Pioneer ACO Model and Medicare Shared Savings Program ACOs show continued quality of care improvements and additional Medicare savings*

- Savings from both the Medicare ACO’s and Pioneer and Shared Savings ACO’s exceed $417 million up from $380 Million reported January 2014

- ACOs qualified for $460 million in shared savings
The average quality scores for Pioneer ACOs in the second year was 85.2%, a 19 percent increase from the 2012 average of 71.8%.

Medicare Share Savings Program ACO’s improved on all but three of the 33 quality measures, including screening for tobacco use and cessation, high blood pressure screening and patient ratings of clinician communication.

Banner Health Network topped $15 million and made up 16% of the total - success was related to supporting beneficiaries most at risk on need after a new diagnosis, following hospital discharge or as a result of multiple emergency department visits.
So far so Good  (2014 CMS Report - continued)

- The Physician Group Practice Demonstration evaluation report confirmed overall savings over the 5 year experience with 7 out of 10 physician group practices measuring shared savings payments totaling $108 million and consistently demonstrated high quality of care on a broad range of chorionic disease and preventative care measures.

- 232 acute care, hospitals, skilled nursing homes, physician group practices, long-term care hospital and home health agencies have entered into agreement to participate in the Bundled Payments for Care Improvement Initiatives.
So far so Great - from the Commercial Payor Perspective

- BCBS - "It's clear we're driving down utilization," AdvocateCare Vice President Lois Elia said. The ACO has reduced hospital admissions per member by 10.6 percent and decreased emergency department visits by 5.4 percent. "The economy impacted some of this," Elia told KHN. "But since our medical cost trend was 6.1 percent below market, it shows our reductions were likely due to prevention of ambulatory-sensitive conditions through better care management, physician access and the like."

- Cigna - Has 86 collaborative accountable care initiatives in 27 states, encompassing more than 880,000 commercial customers and more than 35,000 doctors, including more than 16,000 primary care physicians and more than 19,000 specialists. Cigna launched its first collaborative accountable care program in 2008 and will reach its goal to have 100 of them in place with one million customers in 2014.
So far so Great - from the Commercial Payor Perspective (continued)

- Aetna - Aetna has achieved a high level of success through its accountable care organizations in the last few years—but that accomplishment hasn't come by accident. The insurer is keen on implementing a fresh strategy that empowers providers with unprecedented access to claims data.

- Humana - The Humana-Norton ACO already has improved quality, utilization and physician visits following hospitalization—9 percent decrease in unnecessary antibiotic treatment for adults with bronchitis, 6 percent improvement for diabetic testing and 8 percent improvement for cholesterol management in diabetics. And it has shown an almost 13 percent improvement in appropriate emergency room visits, as well as a 36 percent improvement in physician visits within seven days of discharge, James said.
Objective #6

- Better understand the Exchange and how it may impact your contracting strategy.
Let’s talk about the Exchanges

- https://www.youtube.com/user/USGOVHHS
- High Deductibles
- Leeway to pay premiums
- Know of providers who have provided services and not been paid because insurance was revoked
- On the positive side, for those honest people in the world, at least this will cover the catastrophic cases
- Protect yourself - confirm coverage before providing services
- Obtain waivers in the event coverage lapses
Objective #7

- Consider the future of healthcare reform and how it may impact your business and clinical practice into the years to come.
Challenge Yourself

- Physician contracts directly with employers to provide agreed upon scope of service for a per employee per month fee (no middleman, no claims to file, no delays or denials in payment)

- Communicate with patients using new forms of technology paid a set fee per click or per member per month for limited services
  - Telemedicine (diagnosis and treatment)
  - Internet (secure Skype type connections)

- Establish a virtual clinic with employer groups for an agreed upon scope of service utilizing new technology such as telemedicine in combination with physician extenders located on-site.
Challenge Yourself

- Evaluate your revenue sources
- Shore up the rates you have (FFS) while this movement continues - you live in both worlds now - make the best of it - when was the last time you negotiated rates?
- Get your house in order (revenue cycle, supply costs, lean and mean processes)
- Assess your current IT and analytics capabilities and processes (do your physicians know how they are performing against the measures?)
- Assess your current communication systems (internal and external)
- Identify partners (payors, other providers)
- Look for ways you can impact and lower the cost of care (in your office and through the referral services you control)
- Get ahead of the game and seek out appropriate risk share opportunities (physicians can benefit from controlling the volume and costs in other settings and be paid well for that effort)
Challenge Yourself (examples)

• Ask potential Payor partners to provide you data on services you control, model the impact of changes you can influence and offer a deal they can’t refuse which steers volume to you.

• Negotiate bundled payment for episodes of care within your specialty, accepting the bundled payment and in turn you select the partners (anesthesiology) and facility (hospital, ASC etc.) in which you will work based on quality and efficiency.

• OB/GYN and others with primary care backgrounds expand scope of service to increase volume by providing more primary care to patients.

• Physicians expand or build facilities with lower cost structure than hospitals to provide services that can be provided outside of a hospital or bid out opportunity to hospitals to lease and operate space/staff and perform services.

• Retire early to avoid all this mess (okay that wasn’t thinking outside the box)
Questions?

- Do you have some new tools to assist you in evaluating opportunities for renegotiations?
- Do you see how healthcare reform may impact your practice?
- Do you have the processes and tools in place to be successful into the future? If not, what are your next steps?
- What one thing do you need to do in preparation to successfully make the transition to the future, maintain your market share and enhance revenues?