

Building a Physician-Driven “Super ACO”

Hospital & Physician Relations Executive Summit
Scottsdale, Arizona

March 2, 2015



Boston | Chicago | Houston | Los Angeles | Miami | San Francisco | Washington, DC

Topics to Cover

- What is a “Super ACO?”
- Background on “Sunlight Valley” demographics and market dynamics
- CIN, ACO, and Super ACO development in Sunlight Valley
- Super ACO structural models
- Where things stand today
- Some lessons learned

What is a Super ACO?

Super ACO: A collaborative effort between independent health systems to pursue joint population health management initiatives*

Super ACO Examples

Allspire Health Partners
Bay Area ACO
Granite Healthcare Network
Health Innovations Ohio
Integrated Health Network of Wisconsin
Midwest Health Collaborative
Noble Health Alliance
Northern New England Accountable Care Collaborative
Stratus Healthcare
Together Health

Participants

Atlantic HS (NJ), Hackensack Univ Health Network, Wellspan Health, Lancaster General + 3 other Pennsylvania systems
UCSF, Dignity Health, Hill Physicians, John Muir Health
Concord Hospital, LRG Healthcare + 3 other New Hampshire systems
Summa Health, University Hospitals (Cleveland), Catholic Health Partners, Kettering Health Network, Mt. Carmel Health
Froedtert Health, Wheaton Franciscan Health Care, Columbia-St. Mary's, Medical College of Wisconsin + 2 other Wisconsin systems
Cleveland Clinic, Aultman Hospital, ProMedica, Ohio Health, Premier Health, Tri-Health
Abington Health, Aria Health, Einstein Healthcare Network, Crozer-Keystone Health System
Dartmouth-Hitchcock MC, Fletcher Allen HC, Maine Health, Eastern Maine HS, Dartmouth College
16 regional health systems in Georgia
Ascension Health, Trinity Health

Sunlight Valley Market

- Self-contained market of ~ 425,000 people, with two principal cities
Population growing in “blue collar” city, stable in affluent city
- Two NFP hospitals + one public hospital
“Sunlight Valley Community Hospital (SVCH)” located in affluent city
“Memorial Hospital (MH)” and public hospital located in working class city
- One large primary care medical group; most other PCPs in small practices
- Most specialty groups integrated, cover both hospitals
- Significant Medicaid and Medicare enrollment
- Minimal HMO / HIX penetration (“the land that time forgot”)
- Low West Coast utilization
- High reimbursement (hospital and physicians)
- Health plans driving some out-migration to larger, lower cost market

SVCH is led by a dynamic CEO and was pursuing multiple initiatives to build value-based care and PHM capabilities.

CAPTIVE Launched August 22, 2012	BENEFIT: Compete with Anthem and mitigate migration to Health Insurance Exchanges, which preserves revenue or higher reimbursement rate. It gives SVCH control of minor part of insured market. Goal: Wellness and decrease in expensive inpatient hospital utilization.
KNOX-KEENE Insurance License	BENEFIT: Same as captive but offers more SVCH broader options in the commercial insurance market with goal to keep patients out of hospital and share in the savings (premiums). Goal: decrease inpatient hospital utilization.
MEDICARE ADVANTAGE	BENEFIT: Reduce inpatient loss on growing Medicare Population. Developing means to go at-risk with a specific patient population and participate in shared-savings. This is the whole future of healthcare and SVCH is developing the expertise to survive in the new payment/reimbursement environment.
INDEPENDENT PHYSICIAN ASSOCIATION	BENEFIT: Organized physician group necessary for contracting for insurance product, Medicare advantage, and future bundled payments. SVCH investing time and money to facilitate IPA. MH not at the table.
MEDICAL HOME MODEL	BENEFIT: SVCH Care Managers being placed in our primary care offices, to manage chronic patients. Patients will be referred to preferred providers in SVCH 's network, bypassing MH's system. Goal: is to reduce inpatient utilization and share in savings. SVCH is working with Blue Shield on this initiative.
CMS Joint / Spine Bundled Payment Initiative	BENEFIT: Goal is to reduce loss on joint and spine patients by aligning incentives to reduce and prevent costs associated along continuum of care for those patients. SVCH is selecting preferred providers to participate.
Health Information Exchange (HIE)	BENEFIT: Smooth flow of clinical information between hospital providers, ambulatory providers, and extended care providers will be a key ingredient of population health management and reporting on quality and improvements in health status.
PURCHASE OF VNA HOSPICE	

Memorial, on the other hand, was digging itself out of financial trouble and firmly entrenched in traditional care.

- Financial difficulties had brought Memorial to the brink of bankruptcy
- Pursued a merger that fell through
- Retained Wellspring / Huron to cut costs and provide interim management
- Result was improved financials, but with little attention paid to MH's physician community and no investment in value-based care
- Severe capital constraints would not allow MH to make the kind of investments SVCH was making
- Instead, management and the Board recognized that Memorial's chief asset was its relationship with its independent physicians

Traditionally, MH had enjoyed strong relationships with its medical staff – a “physicians’ hospital”

SVCH, in contrast, was seen by many physicians as “corporate” – organized and well resourced, but less “physician-friendly”

Two strategic moves by SVCH helped convince MH and its physicians to accelerate efforts to pursue value-based care.

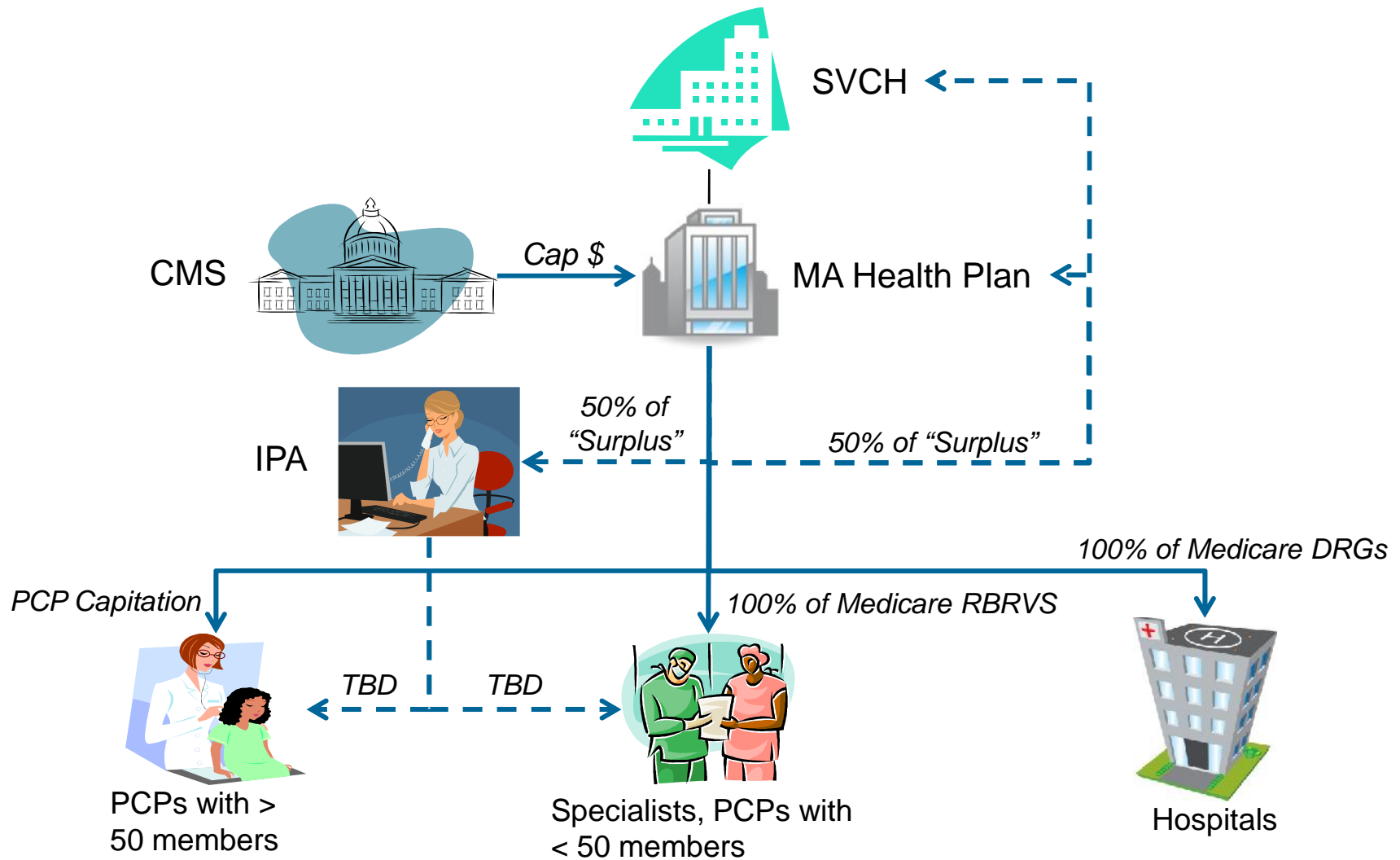
Medicare Advantage (MA) Plan

- SVCH invested in developing an MA plan and began signing up physicians to join an IPA that would provide care to Medicare enrollees
- Plan was wholly owned by SVCH, and MH would be paid Medicare rates for hospital care
- IPA physicians would share 50/50 in savings achieved by the plan
- Whatever the intent, this plan was likely to channel \$ and patients from MH's natural market to SCVH
- In addition, the MA plan could potentially expand into the self-insured market

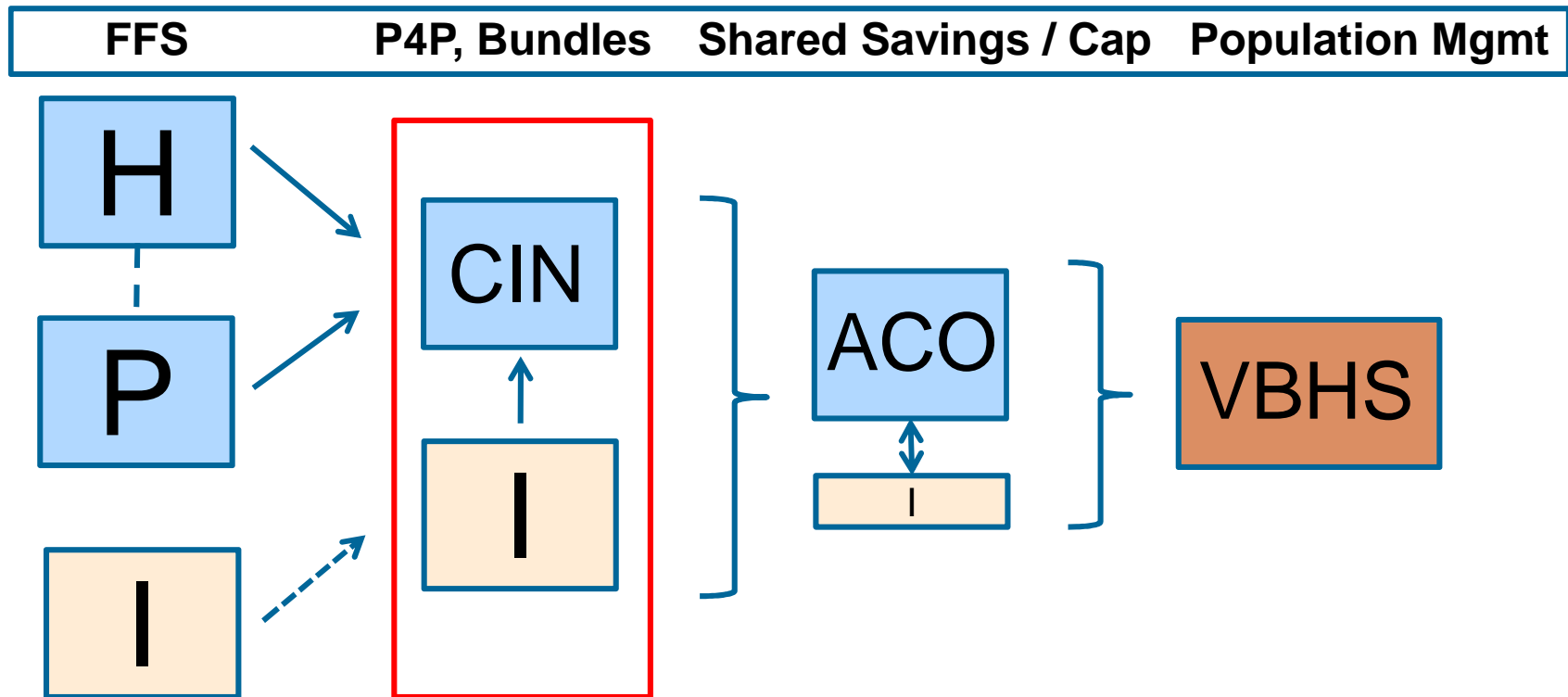
Narrow Network Blue Cross Plan

- SVCH negotiated a narrow network commercial contract with Blue Cross to offer to self-insured employers
- Initially, MH was excluded from the provider panel for this plan
- Physician reaction convinced SVCH and Blue Cross to add MH to the provider panel on the same terms as SVCH
- Ultimate result was a windfall for Blue Cross

SVCH's MA Plan created a total cost of care gain-sharing arrangement with IPA physicians.



Building a clinically integrated network is a key stage in “crossing the crevasse” to value-based care.



H = Hospital

P = Physicians

I = Insurers

CIN = Clinically Integrated Network

ACO = Accountable Care Organization

VBHS = Value-Based Health System (e.g., Kaiser Permanente)

Each stage requires health systems to take on new functions and build new competencies.

Clinical Integration Functions

- Provider network development
- Data analytics
- Care management
- Quality / cost management
- New care delivery vehicles
- Risk contracting

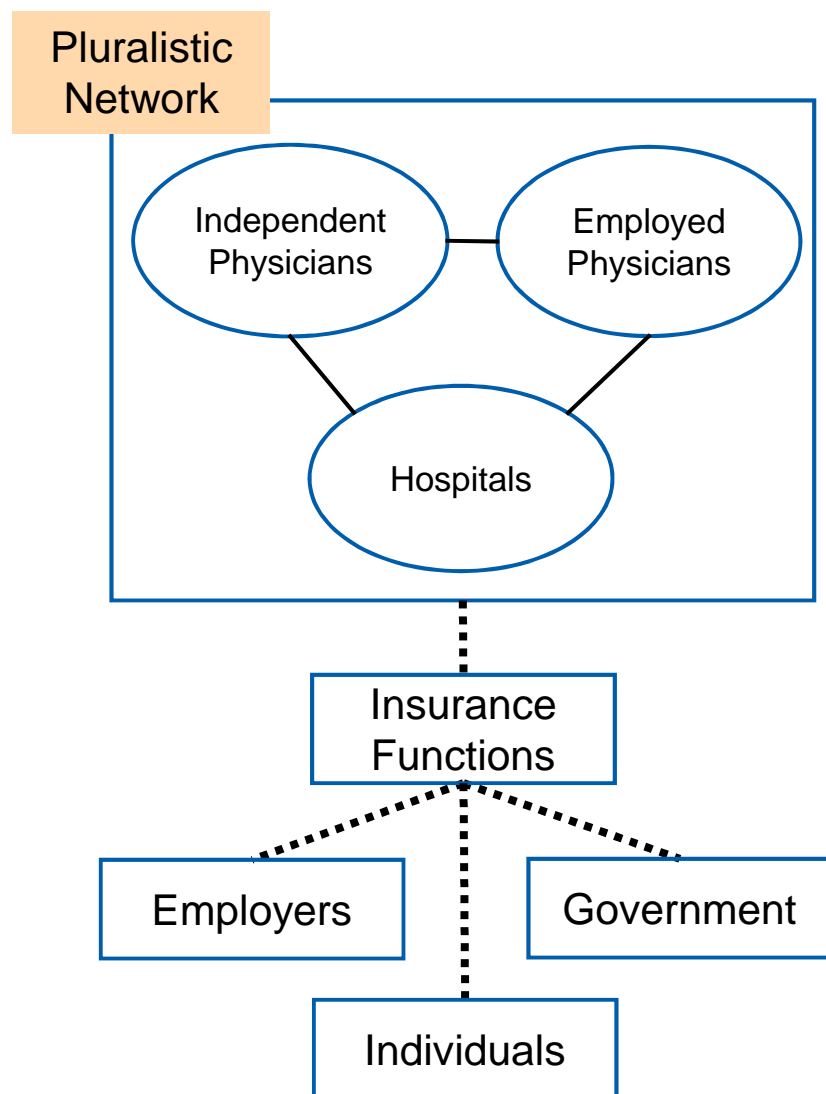
Accountable Care Functions

- Customer needs assessment
- Enrollment & eligibility
- Product & benefit plan design
- Pricing, actuarial & underwriting
- Insurance regulation, risk mgmt
- Reinsurance
- Financial management
- Government relations

Population Mgmt Functions

- Marketing
- Sales / account management
- Member services
- Claims / transaction processing
- Outside contracting
- Integrated data management

Clinically integrated networks are physician-driven organizations aimed at improving quality and affordability.



Key Functions / Structures

- **Clinical management infrastructure**
 - Information-sharing in support of higher quality and lower cost for system as a whole
 - Evidence-based clinical protocols to reduce variation in care
- **Rewards and penalties** for jointly agreed-upon attainable goals (Payer-blind – System administers carrots and sticks)
- **Joint contracting** for hospital and physicians (employed and private) to enable sharing value for improved performance
- **New physician governance construct** to support hospital physician decision making, flow of information, quality initiatives

Clinical integration has been well defined by FTC and DOJ and is distinct from non-risk and full-risk contracting.

Clinical Integration

“... an active and ongoing program to evaluate and modify practice patterns by the network’s physician participants and create a high degree of interdependence and cooperation among the physicians to control costs and ensure quality”

May include:

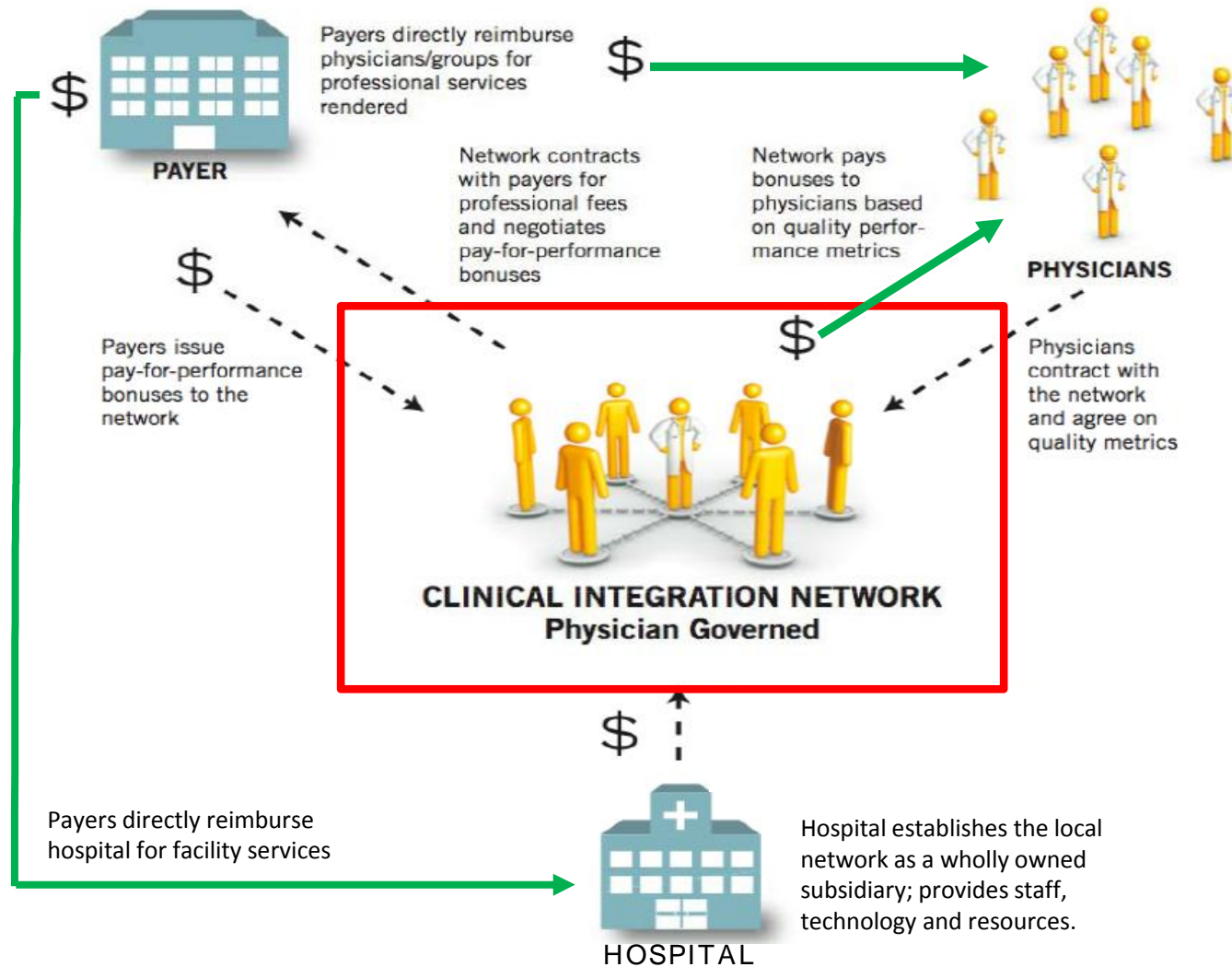
- (1) Establishing mechanisms to monitor and control utilization of health care services that are designed to control costs and assure quality of care;
- (2) Selectively choosing network physicians who are likely to further these efficiency objectives; and
- (3) The significant investment of capital, both monetary and human, in the necessary infrastructure and capability to realize the claimed efficiencies.”

Messenger
Model



Source: FTC/DOJ - Statements of Antitrust Enforcement Policy - 1996

Most CINs are capitalized by hospitals and payers, not physicians.



A clinically integrated network could have important benefits for Memorial and Sunlight Valley.

- Enables MH and its physicians to improve quality, affordability, and patient experience of care (“Triple Aim”) for all the population segments in Monterey County
- Helps the hospital and doctors “cross the crevasse” from FFS to value-based contracting, at a controllable pace and risk
- Engages with payers and employers in designing care management approaches and strategies
- Strengthens integration between doctors, the hospital, and other providers
- Engages physicians to take leadership roles in managing the quality and cost of care
- Reduces incentives for duplicative capital investment and promote appropriate rationalization and consolidation of care

A CIN would also benefit Memorial's physicians by:

- Creating a *physician-driven* organization that can enhance and ensure the delivery of high quality, affordable, patient-centered care to their patients
- Allowing physicians to collaborate with each other and the hospital to participate in value-based contracting
- Enabling physicians to harvest some of the value they create through value-based contracts

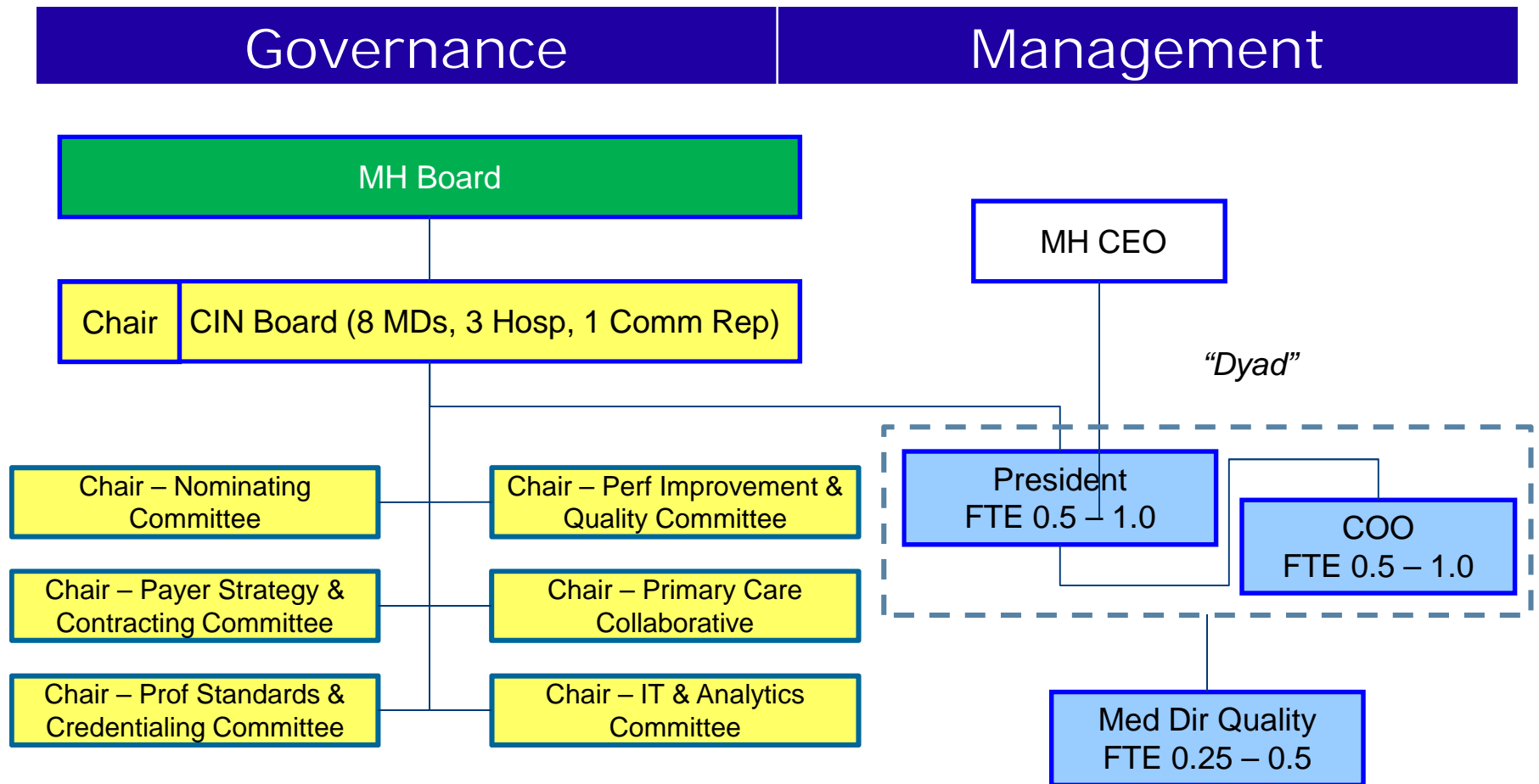
In addition, a CIN would:

- Obviate any need to make changes in professional corporations, retirement plans, real estate ownership, etc.
- Not require physicians to make significant capital investments (capitalized initially by MH and payers)
- Help recruit new physicians into the market
- Increase alignment among physicians and with the hospital
- Strengthen MH's competitive position – an appropriate response to SVCH

Over the next few months, a Physician Design Committee met every two weeks to design MH's CIN.

Meetings	CIN Physician Design Committee – Topics Covered	
Meeting #1	<ul style="list-style-type: none"> • Orientation—Why CIN? • Examples of CINs • Network Vision & Design Principles 	<ul style="list-style-type: none"> • Value Proposition • Future Schedule
Meeting #2	<ul style="list-style-type: none"> • Network Goals (finalize) • Legal Structure (finalize) • Governance 	<ul style="list-style-type: none"> • Management Organization • Network Scope
Meeting #3	<ul style="list-style-type: none"> • Governance (finalize) • Membership Requirements & Obligations 	<ul style="list-style-type: none"> • Operating & Participation Agreements • Naming options
Meeting #4	<ul style="list-style-type: none"> • Staff Task Forces Recruiting Task Force I/T Task Force, Contracting Task Force 	<ul style="list-style-type: none"> • Staff Interim Nominating Committee • Select CIN Name • Legal Documents First Review
Meeting #5	<ul style="list-style-type: none"> • Business Plan Framework • Legal Documents Review 	<ul style="list-style-type: none"> • Phase III Implementation Plan – Initial discussion
Meeting #6	<ul style="list-style-type: none"> • Approve CIN Board • Reports by Task Forces 	<ul style="list-style-type: none"> • Management Team • Legal Document Final Review
Meeting #7	<ul style="list-style-type: none"> • Board Kick-Off Meeting (as Provisional Board) 	<ul style="list-style-type: none"> • Phase III Implementation Plan

After a few months of work, Memorial's CIN was incorporated, its Board seated, and a President appointed.



Importantly, physician Board members represented many of the respected and influential primary care and specialty groups in the Valley.

From CIN to Super ACO...

- Once the CIN was launched, it began working on several implementation tasks – e.g.:
 - Developing a value-based contract for MH’s employee health plan
 - Educating members about I/T infrastructure requirements and vendors
 - Deciding on an initial set of clinical performance metrics to focus on
- However, the CIN Board decided to hold off launching a membership drive and “pulling the trigger” on its own infrastructure development
- Instead, Board members reached out to SVCH and the IPA created for its MA plan to explore how the two hospitals could collaborate with the physicians on infrastructure development, market-facing initiatives, and governance

Arguments for collaborative development of population management skills & infrastructure were compelling.

- Small size and diversity of Sunlight Valley population makes competing ACOs expensive
- Dealing with duplicate infrastructure is inefficient for medical groups covering both hospitals
- Large employers don't want to pay for duplicate resources
- Overlap of medical staffs makes collaboration feasible
- ACO development offers many opportunities for collaboration

<i>Benefits of Collaboration</i>	<i>Costs / Risks of Collaboration</i>
<ul style="list-style-type: none"> • Economies of scale in developing joint infrastructure and new capabilities • Reduced duplication in care delivery • Unified interfaces with physicians, patients / members, payers / employers • Greater scale can accelerate progress toward risk-sharing • Greater ability to retain referrals in the County 	<ul style="list-style-type: none"> • Regulatory concern about the potential for Super ACO to raise prices above competitive levels • Potential health plan, employer resistance • Requires symmetric governance, management structure & systems

In principle, most synergies could be realized with an ACSO, but the systems would still compete in the market.

<i>Functions</i>	<i>Potential Synergies – ACSO Functions</i>
IT and Analytics	<ul style="list-style-type: none"> • Common HIE • Unified disease registry, master person index • Unified clinical scorecards, performance metrics • Shared population health management tools – e.g., alerts, etc. • Common physician reporting tools
Care Management	<ul style="list-style-type: none"> • Integrated local and telephonic care management and case management staff, infrastructure • Shared call center for self-insured employers • Common PCMH, PCMN models • Common Transitions of Care program
Employee & Dependent Health	<ul style="list-style-type: none"> • Shared back office functions • Shared call center for plan members from both institutions
Clinical Program Development	<ul style="list-style-type: none"> • Joint planning to fill clinical gaps (e.g., behavioral health) • Unified County-wide trauma program
Claims Processing	<ul style="list-style-type: none"> • Joint contract to exploit economies of scale
<i>Functions</i>	<i>Potential Synergies – ACO Functions</i>
Segment-specific “go-to-market” initiatives	<ul style="list-style-type: none"> • Medicaid – Unified performance-based contract with Medicaid plan • Medicare Advantage – Joint venture MA plan, merge IPA with CIN • Self-Insured Employers – Unified performance-based contracts

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- Physicians strongly preferred Model B – a Super ACO, with the IPA and CIN closely linked together.
 - Physicians also wanted an ownership interest in the Super ACO, which could be achieved through a separate LLC.

Super ACO discussions with SVCH began a year ago, and progress has been slow.

- Anti-trust counsel was engaged to review feasibility of the Super ACO
 - CIN and IPA defined a way to link the two organizations
 - Decision was made to utilize SVCH's TPA for MH's employee health plan and other value-based contracts
 - Some agreements were reached concerning I/T infrastructure
 - SVCH has offered MH an opportunity to buy into its care management infrastructure, which MH is considering
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- In parallel with these activities, however, both hospitals have been acquiring physician practices. Cardiology, Ob/Gyn, oncology, orthopedics, and primary care practices are being acquired using different types of employment vehicles

Lessons Learned (so far)

Findings

- While Super ACOs are conceptually attractive, they compete for resources and attention with partners' internal initiatives, and they often lose
- Physicians working in concert can mitigate hospital competition by “just saying no”
- Where joint action is required, physicians can lead hospitals to water, but they can't make them drink
- Structuring Super ACO relationships with direct competitors is Sisyphean work, requiring visionary community leadership

Hypotheses

- Substantial resources and staying power are needed to force health systems to restructure their relationships and behavior. Independent physician practices are vulnerable to economic pressures and unlikely to sustain Super ACO development on their own
- Community Board members could help Super ACOs develop by appointing hospital leaders committed to integration
- Health plans could also be development partners for physician-driven Super ACOs
- Small steps may work better than big ideas in developing Super ACOs