The Impact of Value Based Products on Physicians, Hospitals and Payers

- CIO, ACO and Super CIO Models
- Primary and Specialty Care Payment Structures

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Presentation Overview

1) Payer Revenue Stream Changes Accelerate Value Based Product Development

2) Drivers and Challenges in Health Care Today
   – Environmental Impetus to Value Based Care

3) Governance/Management/Operational Structures for CIOs/ACOs and Super CIOs
   – The “Optimal” Clinical/Business Models

4) Specialty CIO Strategies
   – Specialty CIOs Increasing in Numbers and CIO Development Priorities
   – Shared Savings and Bundled Payment Methodologies

5) Primary Care/Population Based CIO/ACO Strategies
   – The Medicare Shared Saving Program (MSSP)
   – Building a MSSP ACO

6) Conclusions and Enterprise Imperatives

Appendix
   – Additional CIO/ACO Formation Considerations
Payer Revenue Stream Changes Accelerate Value Based Product Development

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Governmental Impacts On Key Revenue Sources

**Balanced Budget Act (1997)**
Sustainable Growth Rate (SGR) established, now a $300+ billion underfunded liability related to physician reimbursement rates

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

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

**Tax Relief and Health Care Act (2006)**
Medicare Medical Home Project begins in eight states

**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. **Value Based Reimbursement and Products** are key components of the new law.

- **Supreme Court Decision** – 6/2012
  ACA is Constitutional; Medicaid Mandate is limited/determined by individual states without penalty

- **Obama Re Election** – 11/2012
  Multiple Provisions of ACA unlikely to be repealed, multiple state decisions, Value Based Reimbursement remains critical, $ 500 billion “back loaded provider shortfall”, SGR continues to grow

- **Fiscal Cliff Averted 1/13**
  Deficit /Debt Ceiling Debate Q1 2013
  Multiple critical governmental spending program decisions “kicked” down the road (e.g., SGR, Medicare/Medicaid Cuts, etc.)

**Health Insurance Exchanges Go Live (2014)**
- 25-30 million people without coverage will go into some type of health insurance exchange - state based, federal default and/or private option
- Even states with federal default exchanges will have some say over benefit inclusion above federal essential benefit requirements

**BOTTOM LINE**

Profound changes ahead for all health care organizations

- Legislation
- Regulations
- Guidelines
- Opinions
- Rulings

Changing by the month
Redistribution of Revenue by Payer Product Category* – Regional Health System Payer Mix – Commercial Dominant Example

ACA “ROLLOUT”

2012 --------------- Sub-Segments --------------- Sub-Segment Transitions --------------- 2014

Commercial 45%
- Commercial – Individual
- Commercial – Sm./Mid. Group
- Commercial – Large Group

Medicaid 18%
- Medicaid > 133%
- Medicaid < 133%

Uninsured 12%
- Uninsured > 133%
- Uninsured < 133%
- Undocumented

Medicare 25%
- Medicare FFS
- Medicare Advantage

Remaining Commercial
- Commercial ➔ Exchange
- Medicaid ➔ Exchange
- Uninsured ➔ Exchange
- Commercial ➔ Medicaid
- Remaining Medicaid
- Remaining Uninsured

Commercial and Commercial VBP 36%
- Exchange VBP 9%
- Medicaid VBP 24%
- Uninsured 6%
- Medicare and Medicare VBP 25%

* Developed from SSB Proprietary Data Base 2013
A Value Based/Risk Product Model
– Reimbursement Continuum

One Hundred Patients

- Different reimbursement models will be applied for different subsets of patients
- Shared Savings Most commonly used for population based reimbursement (e.g., MSSP)
- Bundled Payments most commonly used for episodes of care with some type of procedure or high cost intervention (e.g., joint replacement)
CIOs/ACOs/Super CIOs Competing for Payer Products

Competing CIOs/ACOs and Super CIOs/ACOs

HOW WILL PAYERS CHOOSE PREFERRED CIO/ACO PARTNERS?

• Attractive geographic coverage
• Competitive price points-physicians and hospital services
• Scope of clinical services/care model flexibility
• Superior performance on key network metrics
  • Quality/patient safety
  • Appropriate resource utilization
  • Patient and provider satisfaction

CIO/ACO COMPETENCIES
• Organizing fragmented, pluralistic physicians
• Addressing entire continuum of care (inpatient + outpatient)
• Creating advanced care delivery models

Payer

Value Based Products
• Targeted population
• Targeted benefit package
• Targeted payment mechanism

PAYER COMPETENCIES
• Knowledge of markets for insurance products
• Benefit plan design
• Marketing, enrollment and plan administration
• Claims processing
CIO/ACO Aggregation Is Facilitating “Super” CIO/ACO Creation

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

Contracts
Payers
Revenue

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

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

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

Payers

Contracts

Revenue

Organization 4
Contracted Services
Enterprise, Site Specific, Specialty, etc.

Organization 3

Organization 3

• 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
Drivers and Challenges in Health Care Today
– Environmental Impetus to Value Based Care

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PROPRIETARY AND CONFIDENTIAL
Navigating the Perfect Storm – FFS System No Longer Viable

Too much cost
Too many patients
Too little funding
Too few professionals

U.S.S. Healthcare System
Fee for Volume Is Evolving to Fee for Value – Value Based Reimbursement/Products/Plans

**CURRENT SYSTEM**

Fee-for-Service (1-3 Revenue Streams to Providers)
- Referred to as Fee-for-Volume Reward volume over value of services
- Less than optimal 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

**REFORMS TO REDUCE COSTS**

Value-Based Payment (As many as 7 Revenue Streams to Providers)
- 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
- Pay for “Care Management”
- Pay based on evidence-based care
- Payments tied to measurable standards clear to providers and consumers
- Mobility of Care - Taking the right care to right place as well as optimizing existing bricks and mortar
CIO/ACOs Provide the Clinical/Business/Legal Structure for Value Based Reimbursement/Products/Plans

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

“Meaningful Clinical Integration”

Fee-for-Service  Value Based

$  $  $

Minimum Requirements for an Integrated Health System Structure to be a CIO/ACO:

- Establish a state based legal entity such as an LLC, Taxable Non Profit, 501(c) 3, etc. that can enter into highly product specific contractual reimbursement relationships with selective use of FFS, Value Based, Capitated arrangements, etc.

- Achievement of an FTC Compliant Clinical Integration Model to prioritize participation in 2014 State-Based Insurance Exchanges and additional Commercial Value Based Product Offerings for the individual and small group markets

- Support/Create transformational Clinical care models compatible with “next generation” Bundled care, Shared Savings programs, Comprehensive Care Medical Homes, exchange products, etc.

Definitions:

- A CIO is legal entity structured to hold contracts for any VB product (e.g., Commercial, Medicare SSP ACO, Medicaid, etc.)

- An ACO refers to a state based entity that qualifies for participation in the Medicare SSP ACO program but the term has been used interchangeably in CA, MA, etc. for state specific value based commercial programs (e.g., “Massachusetts Commercial ACO” Plan)
“Clinically Integrated Organization” Common Elements
– VB Plans Have Tiers of Lower Cost “Usually Smaller Networks”

1. Employed Physicians
2. Independent Medical Staff – Individuals/Medical Groups and/or PO and/or IPA and/or Specialty CIO
3. Hospital Facilities (Hospitals/ASCs/JVs/DME/HH/SNF)
4. PHO Physicians and/or Specialty Networks

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

“Meaningful Clinical Integration”

- Physicians (employed and independents) working together
- Integrating physician practices with hospital practices
- Integrating full continuum of care
- Evolving interface between health system and payers requires clinical Integration
- Patient-centric care

PAYERS

Fee-for-Service

Value Based

$ $ $
All Health Plans Have a CIO Integration Strategy for Developing Commercial VBPs and MSSP ACOs – Aetna Example
A Primary Care CIO or Specialty CIO Allows for a Spectrum of Risk Based Payment Methodologies

The Value Based Risk Management Profile is Highly Market/Institutionally Specific

- Managing Physician/Hospital Risk Parameters are part of a “Learning Organization”
- An optimized “CIO” is the epitome of a physician aligned “Learning Organization”
- Health plans would like to learn how to create “physician aligned” risk bearing entities (e.g., MGs/IPAs/CIOs) faster than providers for a market specific strategic advantage
FFS Value Based Reimbursement Model
– 5 Source MCI Provider Revenue Stream VBP Example

CIO/ACO/Health Plan Top Line
“Premium Revenue”

MLR = FFS + VB Performance Payments

Fee-for-Service Schedule

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

CLINICAL QUALITY TARGETS

TARGETS

PATIENT SATISFACTION TARGETS

PLAN/CIO/ACO SHARED SAVINGS
Value Based Incentive Payments Are Distributed to Providers According to Rules Set by the CIO/ACO

VBP Incentive Payments  For Distribution = Quality Incentive Fees, Patient Care Incentive Fees, Shared Savings, etc.

CIO/ACO Value Based reimbursement is based on mutual shared savings and meeting quality metrics
- ACO has 33 VBP metrics
- Some commercial-based products pushing towards 100 VBP metrics with 20-35 having quantitative actuarial value
- Medicaid will eventually migrate to VBP metrics (e.g., 39 other states and expanding)
Key Issues

More Patient Contact = Less Total Cost

- Quality Data Monitoring Challenges
- Attribution should be at 75% for Maximum Bonus

Risk Adjusted Allowed Charges (PMPM)

Group 1
At least one visit in CIO
533 Patients
$290 → $310
7% More Expensive

Group 2
50% of visits in CIO
358 Patients
$306 → $275
10% Less Expensive

Group 3
75% of visits in CIO
275 Patients
$323 → $258
20% Less Expensive

North East Medical Group / BC Value Based Pilot 2012
Managing Reimbursement Increasingly Complex

Alternative reimbursement methodologies will occur simultaneously and require different types of physician/hospital alignment models.

![Graph showing the transition from Aggregate FFS Revenue to Aggregate Value Based/CIO Revenue over the years 2012 to 2020.](image)
Future Revenue Under Alternative Strategies

- Payers increasingly expect providers to deliver improved care management models and be held accountable for associated performance metrics
- This will result in lower demand and reimbursement rates for fee for service plans
- This will also result in greater demand for and opportunities with value based plans
Governance/Management/Operational Structures for CIOs / ACOs and Super CIOs
– The “Optimal” Clinical/Business Models
Key Agreements Required for CIO/ACO Formation

- Medicare Shared Savings Program
- Commercial Payers
- Network Management Services
  - CIO/ACO Solutions Vendor
  - CIO/ACO Solutions Vendor
  - CIO/ACO Solutions Vendor

Operating Agreement For CIO/ACO, LLC

Bylaws of PO

50%

Physician Organization, Inc. (TBD)

50%

CIO/ACO Management, LLC

Membership Agreement

Network Participation Agreements

Trademark License Agreement

50%

Hospital

Commercial Payers

Management Agreements

CIO/ACO Solutions Vendor

CIO/ACO Solutions Vendor

CIO/ACO Solutions Vendor
Required Organizational Competencies for CIOs/ACOs

Value Based CIOs require essential capabilities to maximize operational and financial success

Organizational Structure and Leadership
Create a “one enterprise” culture with shared accountability and risk/reward

Care Delivery Transformation
Implementation of evidence-based practices, patient engagement, seamless care transitions, and capacity optimization.

Physician Engagement
Educate and engage physicians to participate energetically in CIO leadership and leadership of the clinical model transformation.

Financial Modeling
Understand start-up and operating budget; 3-5 year financial projections.

Clinically Integrated Organization

Network Development
Develop and mature the CIO network to meet payer needs and enable maximum health system flexibility/options.

Payer Engagement
Short Term
Add sufficient size and scope to the delivery system to enhance its attractiveness to payers.

Intermediate Term
Collaborate with government, private payers, and employers to reward value and build accountability for managing healthcare quality/costs.

CIO Infrastructure
Administrative services
Budgeting/financial modeling
Clinical model
Operational model
IT requirements
Clinically Integrated Organization (CIO) Formation Requires At Least Four Discrete Projects or Processes

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

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

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

Medical Staff Collaboration Project
- Education
- Engagement
- Structure for collaboration? Delegated Functionality
Key Components of Care Management Model – Medical Group, IPA, Network, etc.

OUTREACH AND ENGAGEMENT
- Health management
- Wellness promotion

CHRONIC DISEASE MANAGEMENT
- Disease management for patients with common health conditions
- Case management for patients with multiple diagnoses compounded by social and behavioral issues
- Catastrophic or complex case management

PHARMACY MANAGEMENT
- Appropriate use of drugs
- Prevent inefficient drug utilization
- Prevent fraud, abuse and misuse
- Reconcile medications between care settings

OUTCOME MEASUREMENT
- Benchmarking and identification of best practices
- Reporting of accurate, actionable and timely information
- Patient and Provider Satisfaction measurement

PROCESS IMPROVEMENT AND INNOVATION
- Define new approaches to improve outcomes

INPATIENT CARE
- Identify patients admitted to IP and observation status
- Use standard criteria for appropriate level of care and length of stay
- Intensify focus on discharge planning

CARE TRANSITIONS
- Manage patients care post-discharge
- Coordination of care between providers and community resources
- Prevention of avoidable re-admissions

ACO Clinical Model
CIO/ACO Medical Home Ecosystem - Evolving

Patient Panel
- Primary care services
- Disease management
- Prevention/wellness

Health Information Exchange
- Clinical Metrics
- MLR Metrics

Care management
- Patient communication and engagement
- Quality and safety
- Enhanced access

Payers
CIO/ACO
- Manage population health

Attribution
- Patient Stratification

Care Management Fees
- Performance Bonuses
- Shared Savings

Clinical metrics and disease targets
Clinical protocols
Performance tracking

EMR
Disease Registries

Shared clinical data
Care transitions

Community Resources
Family

Hospital and Specialists

Clinical Resources
The CIO/ACO Healthcare Scheduling Exchange Becomes Critical to New Clinical Model and Business Model*

HIE and EMR
Personal Health Record
Chronic Condition
Wellness / Prevention
mHealth
Concierge Contact Center

myhealthplan.com

PMS and Clinical Decision Support
Claims/EDI
ACOs
Hospital HIS
TeleHealth/ Collaborative Care
Primary Care Medical Homes
Specialists, Lab, ASC, Behavioral, Dental

* Adapted from MyHealthDirect
# Traditional/Historical PHOs vs. CIOs/ACOs

## Key Takeaways
- **CIO/ACO planning/development will involve representative physician leadership and input from the outset**
- **Opportunity for physicians to organize themselves for participation in CIO/ACO governance and management structure**
- **Clinical integration strategy is physician-driven**

<table>
<thead>
<tr>
<th>Previous PHOs</th>
<th>Commercial CIO/ MSSP ACO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ineffective utilization management</td>
<td>Appropriate utilization (and demonstrated quality) by providers</td>
</tr>
<tr>
<td>Capitation and withholds</td>
<td>FFS plus incentives</td>
</tr>
<tr>
<td>Full risk contracts at outset</td>
<td>Increasing risk as CIO/ACO matures</td>
</tr>
<tr>
<td>Payer-centric leadership</td>
<td>Physician and provider led</td>
</tr>
<tr>
<td>Limited technology support</td>
<td>Widely-shared technology infrastructure</td>
</tr>
<tr>
<td>No active care management</td>
<td>Care management, including chronic disease</td>
</tr>
</tbody>
</table>
Specialty CIO Strategies

- Specialty CIOs Increasing in Numbers and CIO Development Priorities

- Shared Savings and Bundled Payment Methodologies

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ABC Orthopedic Hospital Inpatient joint replacement surgery and Inpatient spine surgery represent $139 MM in inpatient revenue (70%)

- **Spine Procedures (Low Complexity)**: $10.4 MM, 449 cases
- **Primary Joint Replacement (Low Complexity)**: $93.0 MM, 5,006 cases
- **Primary Joint Replacement (High Complexity)**: $27.7 MM, 729 cases
- **Joint Replacement Surgery (Revision Surgery)**: $10.4 MM, 449 cases
- **Spine Surgery (High Complexity)**: $6.1 MM, 294 cases
- **$1.9 MM, 86 cases**

MSK Diseases and Conditions (Population Based Care)

- **Integration Required**
- **Level of Risk**
  - Low
  - High
- **Time**
  - Near Term
  - Long Term

Over time, new mechanisms will be required to address a broader inpatient experience along with the outpatient continuum.
<table>
<thead>
<tr>
<th>Surgical Episodes</th>
<th>Complexity</th>
<th>Low</th>
<th>Medium</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arthroplasty</td>
<td>80%</td>
<td>15%</td>
<td></td>
<td>5%</td>
</tr>
<tr>
<td>Spine Surgery</td>
<td>15%</td>
<td>20%</td>
<td></td>
<td>65%</td>
</tr>
<tr>
<td>Sports Medicine Injuries</td>
<td>?</td>
<td>?</td>
<td></td>
<td>?</td>
</tr>
<tr>
<td>Chronic Care</td>
<td>Back Pain</td>
<td>20%</td>
<td>30%</td>
<td>50%</td>
</tr>
<tr>
<td></td>
<td>Osteoarthritis</td>
<td>?</td>
<td>?</td>
<td>?</td>
</tr>
</tbody>
</table>
### Bundled Payment Initiative – Arthroplasty

#### Medicare Episodic Payment National Sample

<table>
<thead>
<tr>
<th>DRG XYZ Joint</th>
<th>Inpatient Hospitalization (Average Cost/Patient)</th>
<th>Post-Acute Care – 30 days (Average Cost/Patient)</th>
<th>Total Average Cost/Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$14,455</td>
<td>$7,510</td>
<td>$21,965</td>
</tr>
</tbody>
</table>

Over 50% of ABC Orthopedic Hospital total arthroplasty patients are discharged directly home.
Evolution of Arthroplasty Revenue Sources

Distribution of Arthroplasty Revenue by Model Type

Today

Future: Shorter-Term

Future: Longer-Term

Bundled Payment

Shared Savings

Fee for Service
Different reimbursement models will be applied for different subsets of patients.

Over time, as ABC Orthopedic Hospital—CIO gains more experience, it will likely want to expand the risk-sharing models and shift patients out of the fee-for-service model.
Patients are Separated into the Appropriate Model

One Hundred Arthroplasty Patients

<table>
<thead>
<tr>
<th>Near-Term</th>
<th>Long-Term</th>
</tr>
</thead>
<tbody>
<tr>
<td>65 Fee For Service</td>
<td>25 Fee For Service</td>
</tr>
<tr>
<td>• Highest Complexity</td>
<td>• Highest Complexity</td>
</tr>
<tr>
<td>• Highest Risk Factors</td>
<td>• Highest Risk Factors</td>
</tr>
<tr>
<td>25 Shared Savings</td>
<td>30 Shared Savings</td>
</tr>
<tr>
<td>• Higher Complexity</td>
<td>• Higher Complexity</td>
</tr>
<tr>
<td>• Higher Risk Factor</td>
<td>• Higher Risk Factor</td>
</tr>
<tr>
<td>10 Bundled Payments</td>
<td>45 Bundled Payments</td>
</tr>
<tr>
<td>• Low Complexity</td>
<td>• Low / Medium Complexity</td>
</tr>
<tr>
<td>• Low Risk Factor</td>
<td>• Low / Medium Risk Factor</td>
</tr>
</tbody>
</table>
Define the Episode and Expected Cost

Define the Episode
- Severity
- Timeframe
- Covered Services

Establish an Expected Cost
Evaluate average historical costs of each episode to establish an expected cost
- Surgeon
- Inpatient hospital
- Other professional
- Imaging
- Post-discharge rehabilitation

Cost Variables
Expected cost per bundle may vary by:
- Severity
- Risk factors (e.g. ASA, BMI)
Types of Shared Savings Models

One-way Shared Savings
- If actual episode costs are less than expected costs, providers share a portion of the savings
- If actual episode costs are greater than expected costs, providers do not share in losses

Two-Way Shared Savings
- If actual episode costs are less than expected costs, providers share a portion of the savings
- If actual episode costs are greater than expected costs, providers share a portion of the losses.

Providers’ share of savings / losses
- Can be any percentage (e.g. providers share 50% of savings or losses)
- If providers share 100% of savings/losses this is a bundled payment
- Provider losses can be capped through stop-loss insurance (e.g. ABC Orthopedic Hospital-CIO is not responsible for costs above $50,000 under Unicare bundled payment)
Calculating Savings/Losses

**Shared Savings**
1. Calculate savings/losses by comparing expected costs to actual costs
2. Allocate savings/losses to ABC Orthopedic Hospital–CIO and insurer based on model formula (e.g., ABC Orthopedic Hospital-CIO receives 50% of any savings/losses)
3. Allocate ABC Orthopedic Hospital–CIO savings/losses among ABC Orthopedic Hospital-CIO providers based on model formula (e.g., surgeons receive 15% of any savings/losses)

**Bundled Payments**
1. Calculate savings/losses by comparing expected costs to actual costs
2. **ABC Orthopedic Hospital–CIO keeps 100% of the savings and bears 100% of the loss.**
3. Allocate ABC Orthopedic Hospital–CIO savings/losses among ABC Orthopedic Hospital–CIO providers based on model formula (e.g., surgeons receive 15% of any savings/losses)
Evaluate Historical Costs to Establish an Expected Cost

<table>
<thead>
<tr>
<th>Category</th>
<th>Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgeon</td>
<td>$15</td>
</tr>
<tr>
<td>Inpatient Hospital</td>
<td>$65</td>
</tr>
<tr>
<td>Other Professional</td>
<td>$7</td>
</tr>
<tr>
<td>Imaging</td>
<td>$5</td>
</tr>
<tr>
<td>Post-discharge rehab</td>
<td>$8</td>
</tr>
<tr>
<td>Expected Cost</td>
<td>$100</td>
</tr>
</tbody>
</table>

These numbers are illustrative
ABC Orthopedic Hospital Low Complexity Joint Replacement Bundle: Initial Thoughts for HPHC

- Low Complexity Defined as ASA 1 and ASA 2
- Duration of the bundle can be phased in over time as our combined risk sharing expertise is further developed

Phase 1:
ABC Orthopedic Hospital-PHO at risk for all services provided including any re-admissions that should occur within this time frame
Future Payer Negotiations – Key Topics

• Episodic payments vs. population-based payments
• Appropriate patients
• The beginning and end of an episode
• Services that are included and services that are excluded
• Targeted level of expenditures and outliers
• Definition of shared savings model, including applicable time period
• Stop loss/cap
• Quality metrics and performance measures
• Balance between expenditure reduction and quality metrics, and how that changes over time.
• Other?
Strategic Value of Specialty CIO

1. Attract new volume from payers, self-insured employers, and Super CIOs seeking to incorporate the ABC Orthopedic Hospital Specialty CIO into their networks

2. Obtain better reimbursement rates thru joint contracting (enabled due to FTC-compliant clinical integration status)

3. Create opportunities for physicians to access additional revenue streams
   - Incentive payments for improvements in quality
   - Incentive payments for improvements in patient satisfaction
   - Shared savings incentives
   - Care management fees for management of chronically ill patients

4. Create MSK specific revenue opportunities to offset financial impact of decreased utilization (?) and reductions in FFS payments

5. Serve as a platform for recruiting additional orthopedic and musculoskeletal physicians to create scale in the market
Primary Care / Population Based CIO/ACO Strategies

- The Medicare Shared Saving Program (MSSP)
- Building a MSSP ACO

SSB Solutions
Snapshot of ACOs

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
  - If ACO enters into value based commercial products it becomes a CIO and the special ACO specific antitrust exemptions must be re-reviewed

- Multiple types of ACOs:
  - Medicare Shared Saving Program ACO is the primary ACO model going forward with a go live target of January 2013. Physician/Hospital Shared Savings are capped at 10% of aggregate cost of patient care (e.g., 5,000 patients at $1,000 pmpm = $60 MM, so the max shared savings would be $6 MM minus administrative fees and development costs).
  - Two primary ACO models being developed by CMS.

- Other programs from the CMS Center for Innovation:
  - Pioneer ACOs
  - Bundled Payments (Global Payment and/or Packaged Payment)
  - Comprehensive Primary Care (Patient-Centered Medical Home), etc.
Summary – CIO/ACO Development Project

- Development, organization, and implementation of a CIO/ACO in order to participate in CMS Medicare Shared Saving Program on January 1, 2013. Total of 106 MSSP ACOs approved in January 2013 bring the total of Pioneer/MSSP ACOs to 260+.

- Potential expansion to include contracting with commercial payers later in 2013 (with some modifications of organization structure possible).

- The ACO development process will focus on:
  - Development of the organizational structure supporting the ACO, including governance and management considerations
  - Medical management and other infrastructure requirements
  - Selection of one or more Management Services Organizations (“MSOs”)
  - Financial and resource analysis
  - Other applicable ACO application requirements
Structure Three Inter-Related Processes Running in Parallel Historical Process for January 1st, 2013 ACO Launch Date

July 2012

ACO Business Planning

ACO Clinical Planning

ACO Application Preparation

Sept. 6, 2012

Planning and preparation continues

Priorities

Inputs, decisions and information

CMS
Necessary ACO/CIO Infrastructure

ACO Infrastructure

- Network Development and Support
- Structure and Governance
- Patient Engagement
- Quality Management and Innovation
- Care Transformation Support
- Information Continuity and Management
- Operations Support
- Finance Analysis and Reporting

Selection of Management Services Organization(s)
- Identify vendors
- RFP process to evaluate capabilities
- Selection of MSO(s) for CIO/ACO
ACO Success Tied to Key CMS Performance Metrics

- Preventative Health
- At Risk Population: Diabetes
- At Risk Population: Ischemic Vascular Disease
- At Risk Population: Heart Failure
- At Risk Population: Coronary Heart Disease
- Patient/Caregiver Experience
- Care Coordination Patient Safety

Better Care for Individuals

Better Care for Populations

ACO Success Tied to Key CMS Performance Metrics
## ACO – Illustration of Potential MSSP Funds Flow

<table>
<thead>
<tr>
<th>Enrollment</th>
<th>Per Member Per Month</th>
<th>Aggregate Annual</th>
<th>Physicians' Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrollment</td>
<td>5,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicare FFS Part A and Part B</td>
<td>$1,000</td>
<td>$60,000,000</td>
<td></td>
</tr>
<tr>
<td>Total Savings:</td>
<td>20%</td>
<td>$200</td>
<td>$12,000,000</td>
</tr>
<tr>
<td>Max Shared Savings:</td>
<td>50%</td>
<td>$100</td>
<td>$6,000,000</td>
</tr>
<tr>
<td>Actual Shared Savings Performance Score:</td>
<td>100%</td>
<td>$100</td>
<td>$6,000,000</td>
</tr>
<tr>
<td>Care Management Fee</td>
<td>$10</td>
<td>$600,000</td>
<td>$600,000</td>
</tr>
<tr>
<td>Administration Infrastructure Fee</td>
<td>$15</td>
<td>$900,000</td>
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<tr>
<td><strong>Net Savings</strong></td>
<td><strong>$75</strong></td>
<td><strong>$4,500,000</strong></td>
<td><strong>$2,250,000</strong></td>
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</tbody>
</table>
### MSSP ACO Revenue Implications – Defensive Rationale, Value Based Product Capability and Market Share Strategy

Assume 5,000 enrollees at $1,000 PMPM

$60 MM in Total Premium Revenue / $12 MM in Maximum Shared Savings

#### Financial Impact on Key Stakeholders

<table>
<thead>
<tr>
<th>Medicare FFS</th>
<th>Medicare ACO with IAD</th>
</tr>
</thead>
</table>

#### CIO/Provider Costs

<table>
<thead>
<tr>
<th>Administration/$15 PMPM</th>
<th>$MM</th>
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<tbody>
<tr>
<td></td>
<td>0.9</td>
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</table>

#### Provider Revenue

<table>
<thead>
<tr>
<th>Inpatient (Hospital)</th>
<th>$MM</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>18.3</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Physician Services</th>
<th>$MM</th>
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<tbody>
<tr>
<td></td>
<td>14.4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pharmacy/OP/Other</th>
<th>$MM</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>15.3</td>
</tr>
</tbody>
</table>

#### Incentive Allocation Distribution (IAD)

<table>
<thead>
<tr>
<th>CMS (50%)</th>
<th>$MM</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>6.00</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hospitals (18.75%)</th>
<th>$MM</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>16.80</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physicians (18.75%)</th>
<th>$MM</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>17.25</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>All PCP Physicians (5%)</th>
<th>$MM</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0.60</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Totals</th>
<th>$MM</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>11.1</td>
</tr>
</tbody>
</table>
Application Summary

Ten page document divided into twelve sections

- Contact information
- General ACO Organization information
- Indication of “Newly Formed” Status
- Legal requirements
- ACO governance
- ACO leadership and management
- Participation in other CMS shared savings programs
- Management of shared savings
- ACO participant information
- Data sharing
- Required clinical processes and patient centeredness
- Certification
## Timeline and Priorities through 2012
### Historical Process for January 1st, 2013 ACO Launch Date

### ACO Launch and Planning

**2012**

**Sept. 6, 2012**
Last day to file ACO application

**Dec. 11, 2012**
Last day for go/no go by CMS regarding ACO candidate

<table>
<thead>
<tr>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Organization of ACO Board and committees</td>
<td>• Responding to CMS queries regarding application</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Recruitment of PCPs</td>
<td>• Working with CMS to incorporate beneficiary assignments</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Obtain signed Provider Participation Agreements</td>
<td>• Working with MSO(s) to prepare for data collection, reporting and other infrastructure requirements</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Completion of CMS ACO application</td>
<td>• Ensure ability to report accurately on 33 performance metrics for 2013</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Selection of MSO(s).</td>
<td>• Work on transformation of care management model</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Initial modeling to determine investment and potential returns</td>
<td>• Assess priorities for managing population and reducing cost of care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

• Prepare for “go-live” operations January 1, 2013.
ACO/CIO Continues to Mature over Time

- Intensive focus on achieving effective connectivity and data sharing between ACO participants (connectivity has special “weight” in compensation formula)
- Accelerate development of medical home models with special focus on managing specific at-risk populations targeted in CMS metrics
- Work with MSO(s) to ensure timely and effective reporting and tracking of utilization
- Develop, promulgate and educate providers on performance tools and tracking
- Determine gaps in clinical and support services and backfill as needed
- Advance discussions with commercial payers regarding value based purchasing
- Explore changes needed to achieve FTC-compliant clinical integration, and evaluate changes needed for entity to contract as CIO

- Develop and implement appropriate strategies to improve operations based on 2013 clinical and financial performance
- Focus on care management strategies to ensure that maximum shared savings is achieved.
- Continue to advance provider connectivity and utilization of online data, reports and alerts
- Move forward with commercial VB contracts
CIOs/ACOs Clinical/Business Model Timing Evolution

Clinically integrated; can begin contracting

Progression to the New Models

PM data from all practices
Protocols, compliance for all specialties from EMRs and vendors
Additional clinical data
Add point of care tools, additional clinical data
Accountable Care Organization: Bundle Payments

Start
3-12 months
18 months
24 months and beyond
Conclusions and Enterprise Imperatives

SSB Solutions

Proprietary and Confidential
Conclusions and Enterprise Imperatives

1. **Physician/Hospital/Payer CIO Strategy Trends:**
   a) Market Consolidation
   b) Tiered and Limited Network Products Begin to take hold, while health systems prepare for full risk
   c) Moving from fee for service to fee for value/value based contracting-products-plans

2. **The Physician/Hospital/Payer CIO Will Facilitate Transition Over Time Into the Leadership Structure necessary for the future:**
   a) PHO/Network/IPA Contracting Evolution
   b) Co Management Projects including contract holding and management services
   c) Value Based Payment- Bundles, Shared Savings, etc.

3. **The Specialty Physician/Hospital CIO Structure and Function will be:**
   a) Designed to meet the clinical and business needs of Physicians, Hospitals and Payers
   b) A “Learning Organization that is more nimble than it’s larger provider competitors and most health plans”
Conclusions and Enterprise Imperatives

**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 purchasing, physician leadership and engagement begin to take center stage
- Optimizing physician/hospital partnering opportunities becomes paramount:
  - Hospital-sponsored medical groups/MD employment
  - Co-management agreements and specialty CIOs
  - Value based network structures
  - Super CIOs begin to form

2003-2009

2010-2011

2012-2014
Conclusions
– A CIO Requires Physician Leadership and Engagement

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

“Meaningful Clinical Integration”

Fee-for-Service  Value Based

CIO Physician Leadership Requirements

- **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 leader 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 product specific care models for complex senior and special needs populations

- **Commercial VBP Exchange Products**: Physician Leadership required to meet VBP targets
Conclusions and Enterprise Imperatives

Building a Performance Driven Clinically Integrated Organization


2) 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.

3) Rigorous business planning and financial modeling must support the Health Plan/CMS payment methodologies
   – Know the rules of the financial model, risk exposure and funds flow specifically for your organization and potential VB product participation.

4) 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.

5) CIOs/ACOs/Super CIOs must be carefully developed and must be a separate legal entity that pass FTC regulations. 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.

6) Successful patient engagement Model is critical.
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
Appendix
– Additional CIO/ACO Formation Considerations
CIOs Require FTC Compliant Clinical Integration*

- Optimizing the Continuum of MD Medical Staff Relationships Especially for Non-Economically Integrated Physicians (e.g., The Independent Medical Staff)

Members of the medical staff

May or May Not Have Additional Contracts

Teaching and Research Agreements

Non Foundation / Non Employed MDs / Independent Physicians

Teaching Faculty

Medical Directors

Professional Services Contracts

Radiology Anesthesiology ER Etc.

Contracted Physicians

Employed or Foundation Physicians

Quality, peer review, privileging & credentialing of all medical staff members

Pluralistic Medical Staff

*If the hospital physician relationship is not “economically integrated”
### FTC Compliant Clinical Integration / Structural Overview

- **At Least Four Organizational Parameters Required for FTC Approval**

**Hospitals and Employed Physicians**

**Independent Physicians**

**MCI Structure Defined by Agreements**

**Organizational Parameters**

<table>
<thead>
<tr>
<th>1) Clinical Scope</th>
<th>2) Membership</th>
<th>3) Performance Improvement</th>
<th>4) Capital Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Encompasses full continuum of care (inpatient, outpatient, alternative care, and collaborative care 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**

**Payers**

**Base Reimbursement**

**Shared Savings**

**Performance Incentives**
Core Payer Strategies Support/Contrast CIO Development

Recurrent Themes from Large For Profit Health Plans


• United, Humana, Aetna, and Cigna are launching or will launch **Value Based Plans (VBPs)** 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. **All want direct “Physician Alignment if possible.”**

• Every major plan views VBPs as creating a **lower price point option** and very attractive to the employer/governmental payer in an environment with or without a formal retail (Exchange) market.

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

• Health plans **under the right circumstances will employ/buy providers** of all types especially PCPs/IPAs/POs
Managing risk requires tiered networks

Tier 1
- FTC compatible meaningful clinical integration infrastructure-baseline
- large network

Tier 2
- CIO network at least 15% smaller than tier 1 with more advanced CI capabilities

Tier 3
- CIO network at least 30% smaller than tier 1 and capable of global payments with performance risk, p4p, etc.

Tier 4
- CIO network at least 45% smaller than tier 1 and capable of accepting global payments with financial risk (e.g., MA capability)

Financial Risk
Clinical Integration

- Consumers
- Employers
- Health Plans
- Government Payors

- Physicians
- Medical Groups
- Hospitals
- Other Providers

*Modified from HFMA materials with SSB Solutions, Inc. proprietary data base
# Payer and CIO Tiered Narrow Network Structures for VBPs*

<table>
<thead>
<tr>
<th>Commercial and MA Products</th>
<th>MSSP ACO ASO</th>
<th>Medicare Advantage</th>
<th>ERISA EE Plan</th>
<th>State Based Exchange</th>
<th>Non Exchange Value Based/ Narrow Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>United</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>— Small &amp; Mid Size Group</td>
<td>Tier 2/3</td>
<td></td>
<td>Tier 2/3</td>
<td>Tier 3</td>
<td>Tier 2/3</td>
</tr>
<tr>
<td>— Large group</td>
<td>Tier 2/3</td>
<td></td>
<td>Tier 2/3</td>
<td>Tier 3</td>
<td>Tier 2/3</td>
</tr>
<tr>
<td>— Medicare Advantage</td>
<td>Tier 2/3</td>
<td></td>
<td>Tier 4</td>
<td></td>
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</tr>
<tr>
<td><strong>BCBS</strong></td>
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</tr>
<tr>
<td>— Individual</td>
<td>Tier 2/3</td>
<td></td>
<td>Tier 2/3</td>
<td>Tier 3</td>
<td>Tier 2/3</td>
</tr>
<tr>
<td>— Small &amp; Mid Size Group</td>
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<td></td>
<td>Tier 2/3</td>
<td>Tier 3</td>
<td>Tier 2/3</td>
</tr>
<tr>
<td>— Medicare Advantage</td>
<td>Tier/ 2/3</td>
<td></td>
<td>Tier 4</td>
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<tr>
<td><strong>Cigna</strong></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>— Mid Size &amp; Large group</td>
<td>Tier 2/3</td>
<td></td>
<td>Tier 2/3</td>
<td>Tier 3</td>
<td>Tier 2/3</td>
</tr>
<tr>
<td>— Medicare Advantage</td>
<td>Tier 2/3</td>
<td></td>
<td>Tier 4</td>
<td></td>
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<tr>
<td><strong>Aetna</strong></td>
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</tr>
<tr>
<td>— Mid Size &amp; Large Group</td>
<td>Tier 2/3</td>
<td></td>
<td>Tier 2/3</td>
<td>Tier 3</td>
<td>Tier 2/3</td>
</tr>
<tr>
<td>— Medicare Advantage</td>
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<td>Tier 4</td>
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<td><strong>Humana</strong></td>
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<tr>
<td>— Medicare Advantage</td>
<td>Tier 2/3</td>
<td></td>
<td>Tier 4</td>
<td></td>
<td></td>
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<td><strong>ERISA / Hospital System</strong></td>
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<tr>
<td>Employee Plans</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Tier 1/2</td>
</tr>
<tr>
<td><strong>Medicare (Non MA Products)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>— MSSP ACO</td>
<td>Tier 2/3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>— CMS Innovation</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>— Pioneer ACO</td>
<td>Tier 2/3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>— Bundled Payment</td>
<td>Tier 2/3</td>
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<td></td>
<td></td>
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<tr>
<td><strong>Medicaid (AHCCCS)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Tier 3/4</td>
</tr>
</tbody>
</table>

*Tier 1 Network- Minimal CIO Capabilities ----- Evolving to Tier 4 ”Risk Products” (e.g., MA)
FFS Payments vs. Value Based/Shared Savings Payments vs. Economic Integration Payments

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

“Meaningful Clinical Integration”

Fee-for-Service

Value Based

\[
\begin{align*}
\text{Standard FFS Payment} & \quad \text{(No MCI)} \\
\text{(No EI)}
\end{align*}
\]

\[
\begin{align*}
\text{Value Based FFS Payment} & \quad \text{(No EI)} \\
\text{(MCI 1+)*} \\
\text{No ACO} & \quad \text{(MC 2+-4+)*}
\end{align*}
\]

\[
\begin{align*}
\% \text{ Premium/Capitation} & \quad \text{(EI – No MCI required)}
\end{align*}
\]

* 1+ MCI = Lower FTC MCI Threshold

* 4+ MCI = Highest FTC MCI Threshold

Health Plan / CMS Reimbursement Methodology
Funds Flow Model: Commercial VB Exchange Product (2014) Represents a 10% Reduction in Employer Costs

Commercial VB Exchange Product @ $384 PMPM

- **Health Plans/CMS**
  - $0.85
  - $0.15

- **Provision of Care**
  - Medical Loss Ratio
  - Inpatient Services: $0.21
  - Physician Services: $0.27
  - Pharmacy and Outpatient Services: $0.27

- **Shared Incentives**: $0.10

- **Administrative Services**
  - Network
  - Clinical Operations
  - Marketing
  - Administrative Operations: $0.10

- **Profit / Contingency**: $0.05

- **Premium Dollar**
  - $0.21
  - $0.27
  - $0.27
  - $0.05
  - $0.10
## Commercial VB Exchange Product Revenue Allocation

Assume 10,000 enrollees at $384 PMPM

### $46.1 MM in Total Premium Revenue

<table>
<thead>
<tr>
<th>Health Plan</th>
<th>$MM</th>
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</thead>
<tbody>
<tr>
<td>Administration</td>
<td>4.6</td>
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<tr>
<td>Profit</td>
<td>2.3</td>
</tr>
<tr>
<td>Total</td>
<td>6.9</td>
</tr>
</tbody>
</table>

### Providers

| Hospital (Inpatient) | 9.8  |
| Physician Services   | 12.5 |
| Pharmacy/OP/Other    | 12.9 |
| Total                | 35.2 |

### Incentive Allocation

| Health Plan (50%) | 2.0  |
| Hospitals (25%)   | 1.0  |
| Physicians (25%)  | 1.0  |
| Total             | 4.0  |

### Financial Impact on Key Stakeholders

#### Commercial FFS vs. Commercial VB Exchange ($MM)

<table>
<thead>
<tr>
<th>Health Plan</th>
<th>Hospitals</th>
<th>Physicians</th>
<th>Pharmacy/OP/Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comm FFS</td>
<td>15.2</td>
<td>13.9</td>
<td>14.3</td>
</tr>
<tr>
<td>Comm VB</td>
<td>10.8</td>
<td>13.5</td>
<td>12.9</td>
</tr>
</tbody>
</table>

---

### Charts

- Bar chart showing revenue allocation among stakeholders.
- Comparison of financial impact between Commercial FFS and Commercial VB Exchange.
Assume 10,000 enrollees at $460 PMPM

$55MM in Total Premium Revenue

<table>
<thead>
<tr>
<th>Health Plan</th>
<th>$MM</th>
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</thead>
<tbody>
<tr>
<td>Administration</td>
<td>5.5</td>
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<tr>
<td>Profit</td>
<td>2.8</td>
</tr>
<tr>
<td>Total</td>
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**Providers**

<table>
<thead>
<tr>
<th></th>
<th>$MM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital (Inpatient)</td>
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<tr>
<td>Physician Services</td>
<td>15.0</td>
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<td>Pharmacy/OP/Other</td>
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<tr>
<td>Total</td>
<td>42.1</td>
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</table>

**Incentive Allocation**

<table>
<thead>
<tr>
<th></th>
<th>$MM</th>
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</thead>
<tbody>
<tr>
<td>Health Plan (50%)</td>
<td>2.3</td>
</tr>
<tr>
<td>Hospitals (25%)</td>
<td>1.2</td>
</tr>
<tr>
<td>Physicians (25%)</td>
<td>1.2</td>
</tr>
<tr>
<td>Total</td>
<td>4.7</td>
</tr>
</tbody>
</table>

Severity-adjustment +20%

Financial Impact on Key Stakeholders
Commercial FFS vs. Commercial VB Exchange ($MM)

- Health Plan: +38%
- Hospitals: -15%
- Physicians: +16%
- Pharmacy/OP/Other: +8%
Summary of Value Based Reimbursement Structure

From CMS/Commercial Payer Shared Savings through CIO/ACO (by creating savings and meeting defined performance targets)

From CIO/ACO to Network PCPs ($5.00-$10.00 PMPM)

From CMS/Commercial Payer to Hospitals and Physicians (in ordinary course)
Model 1: Shared Ownership and Governance

Financial Considerations for Shared Ownership:
- Shared capital contributions
- Shared financial risk

Shared Ownership

HOSPITAL

CIO Management, LLC

50%

CIO Management, LLC Board of Managers

50%

Shared Governance

Physicians (Groups and Solo Practices)
Model 2: Shared Governance

Financial Considerations Arguing Against Shared Ownership:
- “Equity” value is minimal
- Capital contribution requirements
- Financial risk
- Primary value is in allocation of shared savings revenue

CIO Management, LLC

Shared Governance

CIO Management, LLC

Board of Managers

Physicians (Groups and Solo Practices)
CIO/ACO – Governance Structure

CIO/ACO Steering Committee will guide development process until the LLC Board of Managers is formally appointed.

Proposed Board of Managers
- 6 Managers from Hospital
- 6 Physician Managers
- Additional participants
  - Executive Director
  - Chief Medical Officer

Subcommittees

Quality and Clinical Integration
- Credential network providers
- Develop clinical protocols and performance initiatives by specialty
- Monitor and intervene as needed to improve clinical performance
- Set clinical integration priorities based on performance tracking
- Ensure clinical performance monitoring, decision-support and analytics align with organizational priorities

Finance
- Determine and monitor funds flow
- Review and recommend annual capital and operating budgets, for full Board approval
- Review monthly financial reports

Operations and Contracting
- Oversee/review payer contracts
- Monitor operational performance and vendor relationships
- Work with Hospital to develop and oversee marketing and communication plans (physicians and patients)

Information Technology
- Oversee planning and implementation of IT infrastructure requirements
### Work of the CIO/ACO – Key Early Focus

<table>
<thead>
<tr>
<th>Clinical Integration and Quality</th>
<th>Contracts and Finance</th>
<th>I/T and Infrastructure</th>
<th>Co-Management Arrangements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Define quality metrics to propose to payers</td>
<td>Define proposed risk sharing arrangements to propose to payers</td>
<td>Oversee planning and implementation re CIO IT and infrastructure</td>
<td>Co-manage arthroplasty service line</td>
</tr>
<tr>
<td>Set clinical integration and quality improvement priorities based on contracts and performance tracking</td>
<td>Oversee/review payer contracts</td>
<td>Evaluate and select I/T and infrastructure vendor/partners</td>
<td>Co-manage spine service line</td>
</tr>
<tr>
<td>Develop clinical protocols and performance initiatives by specialty</td>
<td>Determine financial aspects of bundled payment initiatives</td>
<td>Monitor EMR adoption and integration throughout CIO</td>
<td>Co-manage Dedham ASC (Sports Medicine)</td>
</tr>
<tr>
<td>Monitor and intervene as needed to improve clinical performance</td>
<td>Determine and monitor funds flow and allocation of incentive payments</td>
<td>Planning for CIO/ACO communication and integration needs</td>
<td>-</td>
</tr>
<tr>
<td>Ensure clinical performance monitoring, decision-support and analytics align with organizational priorities</td>
<td>Review monthly financial reports and recommend areas for performance improvement</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Credential network providers</td>
<td>Review and recommend annual capital and operating budgets, for full Board approval</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>
Meaning of “Sharing Risk”

Only committed physicians will participate
• ABC Orthopedic Hospital–CIO physicians will include a subset of the ABC Orthopedic Hospital admitting physicians
• ABC Orthopedic Hospital–CIO physicians will be those that share in the ABC Orthopedic Hospital–CIO value based product vision and are committed to the ABC Orthopedic Hospital–CIO principles
• ABC Orthopedic Hospital–CIO physicians will be committed to providing superior quality and to continual improvement

ABC Orthopedic Hospital–CIO-specific performance will be measured and reported
• ABC Orthopedic Hospital–CIO will develop and propose to payers performance metrics to be measured
• Only the performance of ABC Orthopedic Hospital–CIO providers will be included in the performance metrics
• ABC Orthopedic Hospital–CIO performance will affect the magnitude of payment it receives from payers

ABC Orthopedic Hospital–CIO will enter into risk-sharing arrangements with insurers
• ABC Orthopedic Hospital–CIO will develop and propose to payers performance targets and associated awards and penalties
• ABC Orthopedic Hospital–CIO will determine the methodology for allocating savings/losses among provider types (e.g. surgeons, hospital, etc.) as well as among individual physicians
Calculation of Gains – Possible Outcome

- **Expected Costs:** $100
- **Costs Better Than Expected:** $75
- **Gain:** $25

Shared Savings
1-Sided Model
ABC Orthopedic Hospital-CIO
Gain: $12.50

Shared Savings
2-Sided Model
ABC Orthopedic Hospital-CIO
Gain: $12.50

Bundled Payment
ABC Orthopedic Hospital-CIO
Gain: $25.00
Calculation of Losses – Possible Outcome

Expected Costs: $100

Costs Worse Than Expected: $115

Loss: $15

- Shared Savings 1-Sided Model
  ABC Orthopedic Hospital-CIO
  Loss: $0

- Shared Savings 2-Sided Model
  ABC Orthopedic Hospital-CIO
  Loss: $7.50

- Bundled Payment
  ABC Orthopedic Hospital-CIO
  Loss: $15.00
Value Based CIOs require essential capabilities to maximize operational and financial success

**Organizational Structure and Leadership**
Create a “one enterprise” culture with shared accountability and risk/reward

**Care Delivery Transformation**
Implementation of evidence-based practices, patient engagement, seamless care transitions, and capacity optimization.

**Physician Engagement**
Educate and engage physicians to participate energetically in CIO leadership and leadership of the clinical model transformation.

**Financial Modeling**
Understand start-up and operating budget; 3-5 year financial projections.

**Network Development**
Develop and mature the CIO network to meet payer needs and enable maximum health system flexibility/options.

**Payer Engagement**

**Short Term**
Add sufficient size and scope to the delivery system to enhance its attractiveness to payers.

**Intermediate Term**
Collaborate with government, private payers, and employers to reward value and build accountability for managing healthcare quality/costs.

**Clinically Integrated Organization**
Administrative services
Budgeting/financial modeling
Clinical model
Operational model
IT requirements
Financial Model: Building Blocks for ACO Financial Model

ACO Revenues: Shared Savings from CMS

- Population size
- Performance scores
- Savings achieved in delivery of care
- Benchmark PMPY

ACO Expense Categories

Start-Up
- Consulting
- Legal
- Compliance training
- IT planning and implementation

Operating
- Staffing
  - Care/quality management
  - Administrative
- Infrastructure
  - Clinical support
  - Network management
  - Connectivity and analytics
Financial Model: Capitalizing the ACO

ACO financial model assumes the shareholders loan the ACO capital to cover selected start-up and working capital requirements
- Ultimate timing and scale of funding requirements is influenced by overall ACO performance and CMS payment schedule
- Financial model assumes interest only payments from ACO to shareholders through end of Y3; pay down of principal thereafter*

Loans from shareholders to ACO
(Loan size decreases once CMS revenues received)

Shared savings earned are distributed in second quarter following each performance year

* Actual loan terms and conditions TBD
MSSP Incentive Award Opportunity

Expenditure Reduction Achieved by ACO \times 50\% \times \text{Performance Score Earned by ACO} = \text{MSSP Shared Savings Award Paid to ACO}

- Part A and Part B claims for beneficiaries attributed to the ACO
- Benchmark projection based on 3 years of CMS data
- In Year 1, requirement is complete and accurate reporting on all measures
- In Years 2 and 3, a performance score is calculated for the ACO
- Total award is capped at 10\% of Benchmark expenditures
- Calculation of award occurs 4-6 months after end of year.

<table>
<thead>
<tr>
<th>Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACO Benchmark $$</td>
</tr>
<tr>
<td>ACO Actual $$</td>
</tr>
</tbody>
</table>

| ACO Portion of Shared Savings $$$$ |
| Preventative Health (8) |
| Care Coordination |
| Patient Safety (6) |
| Patient/Caregiver Experience (7 metrics) |
| Managing At-Risk Populations (12) |

33 Total Performance Metrics

Doctors Physicians Hospital
# ACO Infrastructure Gap Analysis

<table>
<thead>
<tr>
<th>Structure and Governance</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Strong ACO leadership team</td>
<td>No designated leader for ACO as yet (no internal candidate with strong leadership skills yet identified. Need names for application.</td>
</tr>
<tr>
<td>2) Strong clinical leadership</td>
<td>No designated leader as yet; significant structural challenges with current PCPs</td>
</tr>
<tr>
<td>3) Support ACO participant in other locations</td>
<td>Current planning only focused on RWHS resources, but realistically, ACO will need to enlist other independent service providers to expand network coverage and tracking</td>
</tr>
<tr>
<td>4) Analyze, negotiate and manage multiple product offerings</td>
<td>Not possible with current systems. Need to develop more targeted IT infrastructure to support SCO scale-up</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Quality Management and Innovation</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Perform patient stratification and predictive modeling</td>
<td>Not possible with current systems. Need to identify outside vendor to support needed functionality</td>
</tr>
<tr>
<td>2) Track medical resource use (inpatient and outpatient)</td>
<td>Partial reporting possible with existing financial systems assessing RWHS services. Integration of outside ACO providers not possible at this time.</td>
</tr>
<tr>
<td>3) Perform provider profiling</td>
<td>Limited provider profiling in place. Not tied specifically to ACO metrics.</td>
</tr>
<tr>
<td>4) Medication reconciliation</td>
<td>Is done but not captured by all providers in NextGen</td>
</tr>
<tr>
<td>5) Track MSSP ACO metrics</td>
<td>NextGen has capability to track majority of required reporting metrics; however, will require more complete use of system by physicians</td>
</tr>
<tr>
<td>6) Focus on continuous innovation and opportunities for quality improvement</td>
<td>Difficult to achieve due to extremely limited quality tracking and improvement experience within RWPC</td>
</tr>
</tbody>
</table>
# ACO Infrastructure Gap Analysis

<table>
<thead>
<tr>
<th>Patient Engagement</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Attribute and track patients to PCP</td>
<td>Unable to track in NextGen at this time. Could potentially set up special fields to track</td>
</tr>
<tr>
<td>2) Communicate (and track communication) with patients in a variety of ways</td>
<td>Limited to phone calls, and phone tree messaging. There is a field in NextGen to capture some member communication but it is inactive.</td>
</tr>
<tr>
<td>3) Availability and promotion of patient education resources</td>
<td>Limited staff and printed material resources</td>
</tr>
<tr>
<td>4) Patient-directed care initiatives</td>
<td>Not present. Preliminary evaluation of potential development of a new stand-alone member portal. Lowest bid was $850K</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Care Transformation Support</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Plan and implement disease management programs</td>
<td>Not present in current clinical model. Will need outside support to implement and monitor. Needs to tie to medical home development and implementation of disease registries</td>
</tr>
<tr>
<td>2) Manage care across care settings and transitions</td>
<td>Basic discharge planning in place but other transitions (e.g., ER admissions, SNF-related, etc.) not developed or staffed</td>
</tr>
<tr>
<td>3) Use process improvement focused on a system-wide care model</td>
<td>Very limited capabilities, primarily focused on hospital. Need to undertake significant effort to build quality and medical management models and track key processes.</td>
</tr>
<tr>
<td>4) Defined processes for peer review and teamwork</td>
<td>Need to develop new processes based on ACO quality requirements. The current environment does not support decisive peer review and performance/behavior management.</td>
</tr>
</tbody>
</table>
ACO Infrastructure Summary

Information Continuity and Management

1) Provide integrated view of patient information to providers
   - Not all department or providers use EHR. Paper records in different formats are still in use. SNF on separate system; not integrated. Limited patient data available through statewide HIE.

2) Smooth and consistent provider to provider communication
   - Limited due to uneven EHR use among physicians at this time

3) Easy access to clinical protocols and pathways
   - IP protocols in place; no OP protocols are available. Need to develop policies and procedure to adopt and implement new protocols.

4) Health information exchange abilities with suppliers and outside providers
   - Near time submission of certain data. Lab is real time. Problems with timely dictations.

4) Decision support and reporting analytics to assist performance tracking
   - Partial capability through NextGen; need vendor or contractor

Finance Analysis and Reporting

1) Track and report on key performance benchmarks
   - Majority of performance metrics active (or could be activated) in NextGen

2) Track and report on ACO budgets, utilization and other key financial parameters
   - Internal capability needs to be developed

3) Ability to load encounter data for analysis and reporting
   - Potential capability through RWHS TPA organization; needs further evaluation

4) Support multiple reimbursement arrangements
   - No current capability; needs to be developed
# ACO Infrastructure Gap Analysis

<table>
<thead>
<tr>
<th>Operations Support</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Ability to pay care management fees</td>
<td>Not currently available</td>
</tr>
<tr>
<td>2) Portal access for providers</td>
<td>Providers can access IP data</td>
</tr>
<tr>
<td>4) Portal access for patients</td>
<td>Not currently available. Need to prioritize development of selected functionality (online physician communication; scheduling; results)</td>
</tr>
<tr>
<td>5) Call center capabilities</td>
<td>Not currently available. Need to prioritize to expedite access to resources for ACO participants</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Network Development and Support</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Track ACO participants, providers and suppliers</td>
<td>Limited capability to track providers within RWHS. Unable to track utilization of ACO service providers outside RWHS.</td>
</tr>
<tr>
<td>2) Analyze adequacy of ACO’s participants’ network coverage</td>
<td>Not currently available</td>
</tr>
<tr>
<td>3) Support provider enrollment in other ACO products outside of MSSP</td>
<td>Not currently available</td>
</tr>
</tbody>
</table>
### MSSP Quality Measures: Better Care for Individuals

- **Acceptable**
- **Needs Some Development**
- **Needs Significant Development**

#### Patient / Caregiver Experience

<table>
<thead>
<tr>
<th>Measurement</th>
<th>Method of Submission</th>
<th>Findings/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAPHS: Getting Timely Care, Appointments, and Information</td>
<td>Survey</td>
<td>Captured by outside vendor</td>
</tr>
<tr>
<td>CAPHS: How well your Doctor's Communicate</td>
<td>Survey</td>
<td>Captured by outside vendor</td>
</tr>
<tr>
<td>CAPHS: Patient Rating of Doctor</td>
<td>Survey</td>
<td>Captured by outside vendor</td>
</tr>
<tr>
<td>CAPHS: Access to Specialists</td>
<td>Survey</td>
<td>Captured by outside vendor</td>
</tr>
<tr>
<td>CAPHS: Health Promotion and Education</td>
<td>Survey</td>
<td>Captured by outside vendor</td>
</tr>
<tr>
<td>CAPHS: Shared Decision Making</td>
<td>Survey</td>
<td>Captured by outside vendor</td>
</tr>
<tr>
<td>CAPHS Health Status/Functional Status</td>
<td>Survey</td>
<td>Captured by outside vendor</td>
</tr>
</tbody>
</table>
### MSSP Quality Measures: Better Care for Individuals

- **Acceptable**
- **Needs Some Development**
- **Needs Significant Development**

**Care Coordination / Patient Safety**

<table>
<thead>
<tr>
<th>Measurement</th>
<th>Method of Submission</th>
<th>Findings/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk-standardized, all condition readmission: the rate of readmissions within 30 days of discharge from an acute care hospital for assigned ACO beneficiary population</td>
<td>Claims</td>
<td>Will required additional data collection and analytics to ensure timely tracking (rather than waiting for CMS reports)</td>
</tr>
<tr>
<td>Ambulatory sensitive conditions admissions: chronic obstructive pulmonary disease [Findings/Comments prevention quality indicator (PQI) #5]</td>
<td>Claims</td>
<td>Will required additional data collection and analytics to ensure timely tracking (rather than waiting for CMS reports)</td>
</tr>
<tr>
<td>Ambulatory sensitive conditions admissions: congestive heart failure [Findings/Comments prevention quality indicator (PQI) #8]</td>
<td>Claims</td>
<td>Will required additional data collection and analytics to ensure timely tracking (rather than waiting for CMS report)</td>
</tr>
<tr>
<td>Percent of PCPs who successfully qualify for an EHR incentive program payment</td>
<td>EHR Incentive Program</td>
<td>Need to complete NextGen implementation and meaningful use tracking</td>
</tr>
<tr>
<td>Medication reconciliation after discharge from an inpatient facility</td>
<td>GPRO Web Interface</td>
<td>Now done by case managers. Ability to track and analyze for Medicare patients specifically needs to be assessed</td>
</tr>
<tr>
<td>Falls: screening for fall risk</td>
<td>GPRO Web Interface</td>
<td>Not currently used. Could be implemented in NextGen</td>
</tr>
</tbody>
</table>
## MSSP Quality Measures: Better Care for Populations

- **Acceptable**
- **Needs Some Development**
- **Needs Significant Development**

### Preventive Health

<table>
<thead>
<tr>
<th>Measurement</th>
<th>Method of Submission</th>
<th>Findings/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Influenza immunization</td>
<td>GPRO Web Interface</td>
<td>Captured in NextGen</td>
</tr>
<tr>
<td>Pneumococcal vaccination</td>
<td>GPRO Web Interface</td>
<td>Captured in NextGen</td>
</tr>
<tr>
<td>Adult weight screening/ follow up</td>
<td>GPRO Web Interface</td>
<td>Captured in NextGen; however, some clinics do not measure height needed to calculate BMI</td>
</tr>
<tr>
<td>Tobacco use assessment and cessation intervention</td>
<td>GPRO Web Interface</td>
<td>In place as soon as rollout to PCP clinics is complete</td>
</tr>
<tr>
<td>Depression screening</td>
<td>GPRO Web Interface</td>
<td>Available in NextGen; however, screening tools are deep in system and hard to access</td>
</tr>
<tr>
<td>Colorectal cancer screening</td>
<td>GPRO Web Interface</td>
<td>Captured in NextGen</td>
</tr>
<tr>
<td>Mammography screening</td>
<td>GPRO Web Interface</td>
<td>Captured in NextGen</td>
</tr>
<tr>
<td>Proportion of adults who had blood pressure measured within preceding 2 years</td>
<td>GPRO Web Interface</td>
<td>Captured in NextGen</td>
</tr>
</tbody>
</table>
## MSSP Quality Measures: Better Care for Populations

<table>
<thead>
<tr>
<th>At Risk Population: Diabetes</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Measurement</th>
<th>Method of Submission</th>
<th>Findings/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes composite hemoglobin a1c control (&lt;8 percent)</td>
<td>GPRO Web Interface</td>
<td>Captured in NextGen</td>
</tr>
<tr>
<td>Diabetes composite LDL (&lt;100)</td>
<td>GPRO Web Interface</td>
<td>Captured in NextGen</td>
</tr>
<tr>
<td>Diabetes composite: blood pressure &lt;140/90</td>
<td>GPRO Web Interface</td>
<td>Captured in NextGen</td>
</tr>
<tr>
<td>Diabetes composite: tobacco non use</td>
<td>GPRO Web Interface</td>
<td>Not in system</td>
</tr>
<tr>
<td>Diabetes composite: aspirin use</td>
<td>GPRO Web Interface</td>
<td>Captured in NextGen</td>
</tr>
<tr>
<td>Diabetes mellitus: hemoglobin A1c poor control (&gt;9 percent)</td>
<td>GPRO Web Interface</td>
<td>Captured in NextGen</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>At Risk Population: Hypertension</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Measurement</th>
<th>Method of Submission</th>
<th>Findings/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of patient visits for with a diagnosis of HTN with either systolic blood pressure ≥140 mmHg or diastolic blood pressure ≥ 90 mmHg with documented plan of care for hypertension</td>
<td>GPRO Web Interface</td>
<td>Captured in NextGen</td>
</tr>
</tbody>
</table>
# MSSP Quality Measures: Better Care for Populations

- **Acceptable**
- **Needs Some Development**
- **Needs Significant Development**

## At Risk Population: Ischemic Vascular Disease

<table>
<thead>
<tr>
<th>Measurement</th>
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<th>Findings/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>IVD: Complete Lipid Profile and LDL Control &lt;100 mg/d</td>
<td>GPRO Web Interface</td>
<td>Captured in NextGen</td>
</tr>
<tr>
<td>IVD: Use of Aspirin or another anti-thrombic</td>
<td>GPRO Web Interface</td>
<td>Not in system</td>
</tr>
</tbody>
</table>

## At Risk Population: Heart Failure

<table>
<thead>
<tr>
<th>Measurement</th>
<th>Method of Submission</th>
<th>Findings/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beta Blocker Therapy for Left Ventricular Systolic Dysfunction</td>
<td>GPRO Web Interface</td>
<td>Captured in NextGen</td>
</tr>
</tbody>
</table>

## At Risk Population: Coronary Artery Disease

<table>
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<th>Measurement</th>
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<th>Findings/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAD Composite: Drug therapy for lowering LDL cholesterol</td>
<td>GPRO Web Interface</td>
<td>Captured in NextGen</td>
</tr>
<tr>
<td>ACE Inhibitor or ARB therapy for patients with diabetes or left ventricular systolic dysfunction (LVSD)</td>
<td>GPRO Web Interface</td>
<td>Captured in NextGen</td>
</tr>
</tbody>
</table>
MSSP Incentive Award Opportunity

Expenditure Reduction Achieved by ACO

Performance Score Earned by ACO

MSSP Shared Savings Award Paid to ACO

ACO Benchmark $$

ACO Actual $$

10% + 10% savings

Patient/Caregiver Experience

Preventative Health

Care Coordination

Patient Safety

Managing At-Risk Populations

33 Total Performance Metrics

Part A and Part B claims for beneficiaries attributed to the ACO

Benchmark projection based on 3 years of CMS data

In Year 1, requirement is complete and accurate reporting on all measures

In Years 2 and 3, a performance score is calculated for the ACO

Total award is capped at 10% of Benchmark expenditures

Calculation of award occurs 4-6 months after end of year.

ACO Portion of Shared Savings

Physicians

Hospital

ACO Benchmark $$

ACO Actual $$

10% + 10% savings

Preventative Health

Care Coordination

Patient Safety

Managing At-Risk Populations

33 Total Performance Metrics

Part A and Part B claims for beneficiaries attributed to the ACO

Benchmark projection based on 3 years of CMS data

In Year 1, requirement is complete and accurate reporting on all measures

In Years 2 and 3, a performance score is calculated for the ACO

Total award is capped at 10% of Benchmark expenditures

Calculation of award occurs 4-6 months after end of year.

ACO Portion of Shared Savings

Physicians

Hospital
Performance Score Determines % of Incentive Award

• **Year 1**: ACOs must completely and accurately report on all 33 required quality measures.

• **Year 2**: ACOs must meet a minimum quality standard (30th percentile of the national Medicare quality performance rates) in 70% of the required measures in each of the 4 quality domains (25 measures total for Year 2).
  – ACOs must report completely and accurately on 100% of the remaining 8 measures.

• **Year 3**: ACOs must meet a minimum quality standard (30th percentile of the national Medicare quality performance rates) in 70% of each of the 4 quality domains (32 total.)
  – ACOs must accurately and completely report one measure (CAHPS Health/Functional Status).

Clinical quality scores and demonstrated reporting

Weighted average CMS formula generates total score for ACO

Score determines % of achieved shared savings that will be paid to ACO
Up to Four Planning Tracks Underlie CIO Formation

**TRACK 1**
Organizational Planning for CIO
- Analyze contracting opportunities (population; risk)
- Define legal structure
- Define governance
- Define management structure/responsibilities
- Determine infrastructure requirements and fulfillment strategy
- Develop budgets and financial models

**TRACK 2**
Planning for independent Physician Organization (can be concurrent w/ Track 1)
- Clarify for physicians the rationale for change
- Engage physicians in the change process
- Define PO legal structure and governance
- Determine relationship and ownership interest in CIO
- Manage diverse stakeholder interests

**TRACK 3**
Developing New Clinical Models
- Qualify & engage network participants
- Align clinical goals with provider compensation
- Design and promulgate evidence-based guidelines
- Minimize unnecessary practice variation
- Track clinical outcomes across continuum of care
- Integrate enabling technologies

**TRACK 4**
Collaborating with Medical Staff
- Educate and engage medical staff leadership on CIO strategy
- Align functionality across the continuum of care (quality, credentialing, peer review)
- Delegated Board authority for quality
- Governance/mgmt. of “all things clinical”
- Clarify role of MEC(s)
Key Clinical Functionality Across the Continuum of Care Requires Carefully Designed Physician Engagement/Process

**Credentialing**
- New applications
- Simple renewal applications
- More complex renewal applications

**Clinical Quality**
- Monitoring clinical results for identification of “outliers”
- Ongoing monitoring of clinical results and processes
- EBM process, input to quality plan, establish metrics

**Peer Review**
- Adjudicating complex situations e.g.,:
  - Those arising from activities in credentialing ↔ clinical quality
  - Disruptive clinical behavior
  - “Never” patient safety events

**Ambulatory**

**Inpatient**
A CIO/ACO Clinical Integration Committee (CIC) is the Forum for “All Things Clinical” and supports the Medical Staff.
### ABC Orthopedic Hospital – CIO Product Development

#### Conceptual Framework and Principles

<table>
<thead>
<tr>
<th>1</th>
<th>Prioritize Development</th>
<th>• ABC Orthopedic Hospital-CIO will prioritize development of products starting with low-complexity surgeries</th>
</tr>
</thead>
</table>
| 2 | Risk-Sharing Models    | • Different subspecialties will require different types of risk-sharing models  
- Acute care/surgical models  
- Chronic care/medical models  
- Combined models (e.g. low back pain total care) with surgical and medical components |
| 3 | Evolve Over Time       | • The risk-sharing models will evolve over time to accommodate a greater degree of risk taking by ABC Orthopedic Hospital-CIO—as ABC Orthopedic Hospital-CIO gains experience and competency and builds infrastructure |
| 4 | Integrated Care Model  | • For each subspecialty and complexity level, ABC Orthopedic Hospital-CIO will need to develop an integrated care model addressing:  
- Care management  
- Performance metrics  
- Risk Sharing  
- Reimbursement incentives |
ABC Orthopedic Hospital – CIO Product Development Conceptual Framework and Principles (cont’d)

5 Risk-Sharing Continuum Range
• For episode-based service lines such as arthroplasty, the risk-sharing continuum range includes:
  - Fee-for-service payments
  - Shared savings relative to a baseline expected cost per episode
  - Bundled payment per episode (with or without stop-loss for outliers)

6 Less Complex Cases
• For less complex cases, movement along the risk continuum can happen quickly (e.g., bundled payments for very low complexity cases)

7 More Complex cases
• For more complex cases, shared savings may be a more appropriate first step:
  - Mitigates risk initially
  - Allows time to develop and refine tools needed for success with bundled payments:
    o Cost and utilization data capture and reporting
    o Performance metric reporting and refinement
    o Others
ABC Orthopedic Hospital – CIO Product Development
Conceptual Framework and Principles (cont’d)

Contracting Principles

• ABC Orthopedic Hospital–CIO will seek to develop contracts with payers who share our commitment to the following:
  - Paying for Value, Recognizing the Expertise of ABC Orthopedic Hospital Physicians
  - Creating a Relationship that Provides Benefit to All Parties Including the Patient
  - Reduction in TME
  - Joint Infrastructure Development to Support Patient Care Across the Continuum
  - Long Term Perspective - Phased Risk Approach Commensurate with Capability
  - Shared Performance Metrics/Shared Information
  - Share Rewards for Improved Quality and Value