Moving Forward

Building Authentic Population Management through Innovative Payer Relationships

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Executive Summary

Healthcare leaders are well aware of the industry's inevitable transition from volume to value. Fee-for-service (FFS), volume-based payments still prevail, but there exists mounting pressure from all payers (private and public) for providers to transition their care delivery systems in order to accept value-based payments, some involving risk. The overarching goal is for all those involved in the payment puzzle to find a way to curb the unsustainable healthcare cost trajectory.

IN ADDITION TO THE MEDICARE SHARED SAVINGS PROGRAM for accountable care organizations (ACOs), private payers are creating a number of different payment options for providers, both within the FFS structure as well as other, non-FFS payment models. As a result, there has never been more opportunity for payers and providers to work together to develop innovative relationships that have the potential to create cost savings for both sides, while improving quality of care. As described in more detail in this white paper, there is one major common theme among the various payment models currently being explored in the industry: the ability for providers to build a new system that can deliver "authentic care management" using a population health approach.

Managing the health of populations will require a fundamentally new business model that involves new data systems, operations, and management teams. It is natural to think of population health as an extension of standard hospital operations, but the reality is that population health is a different business model. Many of the value-based payment programs can provide seed funding and direction to set up the infrastructure that is required to operate in this business model.

With this appreciation of the business model, it is clear that there is a natural tension between the two: the FFS model drives volume up while population health management drives volume down. That being said, in the right environment there are also opportunities for alignment in which an organization can extract the value left from the volume-based system while building a separate structure for population health management. Hospital and health system leaders need to answer two critical and independent questions:

1. Do we want to get in the population health business (i.e., is this critical to our mission and our ability to operate under a value-based payment system)?
2. How are we going to contract our traditional business with payers (including ACOs) in a population health marketplace (irrespective of whether we decide to get into the population health business)?

What Is Different This Time?

There is a healthy degree of skepticism that the population heath business is going to be a fad similar to the managed care push in the 1990s. This point of view has merit, but there are several reasons why managed care failed to take hold in the past that are being addressed in this current movement, including an enhanced need on the part of employers to reduce benefit cost, more sophisticated data systems available to manage and utilize necessary information about patient populations, more patient options in health plan benefit design, and performance-based payments to incentivize providers to focus on outcomes in addition to costs.

There is no assurance that by correcting the problems of managed care in the past, population health management will work perfectly this time. Healthcare leaders should anticipate and expect a crop of new issues to emerge that could derail the efforts if they are not properly addressed in a timely fashion. A number of market forces are coalescing to ensure that these yet to be articulated issues are managed from the organizations that are embracing population health management and migrating their operations to thrive in this model.

Authentic Care Management

While the problems with the current system are fiercely debated, there is a general consensus that the solution lies in some improved form of care management. The classical care management models have resulted in mixed success for a whole host of reasons, which is why the concept of second-generation care management will be critical for the value solutions.

The solution for many healthcare challenges can be solved with more effective and targeted care management. To understand this model, consider the system today: the doctor today is a reactive model. The doctor is trying to deal with all patients who need to come in for reactive care and no thought is given to the patients whom the doctor is not seeing. The goal is about getting through the day and performing as many services as possible. Visits are oriented around the doctor and not the patient, which leads to significant inefficiencies for the patients. In a

proactive model, doctors will lead a team that is responsible for the health and wellness of a defined population of patients, focusing on those most at risk and with chronic disease, and using technology and new staffing models to deploy the right level of resources for each population. The goal is to keep patients healthy and better manage those with disease by focusing and directing the monitoring and interventions around the patient, resulting in less use of institutions and more directed office visits.

The first step to population health management is to define the population—this is typically a strategic and tactical exercise to determine how patients will be attributed to the program (either by what insurance they have or by what physicians they see). After the population is defined, the next step is to create a functional segmentation. This will help define who is currently sick, who is likely to be sick, and who is well. Once the segments are defined, it is important to determine the needs for each segment. In other words, first determine who needs preventive services, disease screening, case management, disease management, health coaching, and medication management, and then determine the most effective way to deliver the interventions.

Smart Strategies for Providers to Interact with Payers

Healthcare is still a local business and as such it will be critical for providers to understand their local market dynamics in order to select strategies that will bring them success. All providers will need to address a fundamental question, either actively or passively: what are your aspirations with your payers? This can range from simple to fairly complex arrangements. Different strategies will be relevant depending upon the provider organization's aspirations and roadmap.

Popular strategies in order from simple to complex in implementation include the following, which are discussed in more detail in the body of this white paper:

- Continue with the current business model (not recommended as a viable long-term strategy in most communities)
- Implement pay-for-performance (P4P) contracts
- Shared savings, bundled payments, and direct contracting with employers
- Take on full or partial capitation for a population (most self-insured organizations are already doing this)
- Offer an insurance product to other employers or on the exchange

In general, the smart strategy when dealing with payers is to determine how to get closer to the premium dollar while mitigating risk shifting. The traditional percentage-increase contracts are generally accepted to be a thing of the past (although there are scattered reports of some organizations still trying to get these contracts). The more sophisticated organizations are starting with P4P contracts and then migrating to risk-based contracts. Another goal for providers should be to develop an all-payer solution that will make the programs easier to scale and implement.

Discussion Questions for Board Members

1. What are our current financial and clinical results for our inpatient business, outpatient business, and physician enterprise?
    a. How do these results compare to local and national benchmarks?
    b. What is our competition in each area and how are we differentiated?
    c. Can we make money on each line individually if payment were to decline to at or below Medicare rates?
2. What is the current supply and demand for essential healthcare services in our market and how is this going to change over time?
    a. In a market where there is a shortage of hospital beds, it will be difficult for any outside organization to play a significant population health management role.
    b. Primary care physicians are the foundation to a program.
    c. Select specialists based on effectiveness and efficiency.
3. What current competencies do we have for population health management?
    a. Data infrastructure
    b. Management talent and staff with experience in population health management
    c. Patient-centric care management systems
    d. Business processes that have proven results of increased quality and reduced costs
4. What percent of our revenue and profit comes from risk- or performance-based contracts?
    a. What are we doing to manage this business?
    b. How do we expect that business to change in the future?
5. Who in our market is best positioned to be the population health manager?

Introduction

Healthcare leaders are well aware of the industry's inevitable transition from volume to value. Fee-for-service (FFS), volume-based payments still prevail, but there exists mounting pressure from all payers (private and public) for providers to transition their care delivery systems in order to accept value-based payments, some involving risk. The overarching goal is for all those involved in the payment puzzle to find a way to curb the unsustainable healthcare cost trajectory.

IN ADDITION TO THE MEDICARE SHARED SAVINGS PROGRAM for accountable care organizations (ACOs), private payers are creating a number of different payment options for providers, both within the FFS structure as well as other, non-FFS payment models. As a result, there has never been more opportunity for payers and providers to work together to develop innovative relationships that have the potential to create cost savings for both sides, while improving quality of care. As described in more detail in this white paper, there is one major common theme among the various payment models currently being explored in the industry: the ability for providers to enter into an arrangement to do "authentic care management" using a population health approach that will reduce utilization and produce financial benefit for both providers and payers.

Is There a Bridge from Volume to Value?

There are many compelling reasons and explanations for hospitals and health systems to cross the "bridge"—to migrate to this new, value-based business model. That being said, this topic is worthy of some explanation in the context of how to manage the population health "gold rush." The question is whether this bridge will actually take hospitals and health systems to a new delivery model or whether it will be a bridge to nowhere. Perhaps the issue here is the bridge analogy itself—will it be an entirely different mode of transportation?

To extend the metaphor, if ground transportation (i.e., the bridge) represents the current hospital business model (episodic, fee-for-service care), perhaps managing population health is like getting into the airplane business. While both are used for transportation, the skill set to create and operate each is completely different. There are almost no ground transportation companies in the airplane business and vice versa.

Thus, managing the health of populations will require a fundamentally new business model to involve new data systems, operations, and management teams. It is natural to think of population health as an extension of standard hospital operations, but the reality is that population health is a different business model, as demonstrated in **Table 1.**

Table 1. Fee-for-Service vs. Population Health Model

	Fee-for-Service Business	Population Health
Customer	People who are admitted (or use outpatient services)	Everyone who pays for coverage or is enrolled in a plan/program*
Revenue	Paid per unit of service	Monthly fixed amount
Expenses	Primarily labor and facilities	Healthcare services
Data Systems	Cost accounting and billing	Predictive models and care management
Key to Success	Keep occupancy high and expenses low	Increase management and monitoring to reduce unnecessary care

*Note: There is a movement to define the population as everyone who lives in a region regardless of payer class. The definition included in this table and for the purposes of this white paper is relevant for current population health management.

With this appreciation of the business model, it is clear that there is a natural tension between the two: the FFS model drives volume up while population health management drives volume down. It is important to note that hospitals are still going to be paid some form of FFS for inpatient admissions under the population health model. Hospitals will see more admissions from patients who are in plans with some value-based contract and as such, revenue will increasingly come from the population health

management company rather than the traditional payer. Furthermore, the population health management companies will likely have incentive payments that will enhance the FFS model based on performance metrics.

This change in patient plan type is the first step in the process as population health management companies actively drive down revenue per admission. Fighting this force is not a winning long-term strategy in most markets with competition for services. Hospitals and health systems can build the bridge to value by balancing the inpatient revenue and the population health management business. On the other hand, some organizations may choose to focus on one line of primary business and drive results faster through contracts and partnering, capturing an advantage. It will be important for organizations to employ both of these strategies with vigor, even though they could create significant internal imbalances and contradict each other at times, when housed under the same organization.

That being said, in the right environment there are also opportunities for alignment in which both models can flourish. Hospital and health system leaders need to answer two critical and independent questions:

1. Do we want to get in the population health business (i.e., is this critical to our mission and our ability to operate under a value-based payment system)?
2. How are we going to contract our traditional business with payers (including ACOs) in a population health marketplace (irrespective of whether we decide to get into the population health business)?

This white paper will provide insights and facts to help organizations determine their own correct answer for each of these questions, and address how to balance the contradicting strategies of building the bridge to value while at the same time maximizing contract and partnering opportunities in FFS service lines.

A Business Model in Transition

Most adjacent/competing healthcare companies (payers, providers, and others) are trying to get in the population health management business as they see the opportunity for new revenue and to complement their existing businesses (see **Table 2**).

Table 2. Getting into the Population Health Revenue Stream

Who	Motivation	Examples
Physician groups	They have the patient relationship	Many
Pharmacies	They are looking for a feeder to their retail and Rx business and expansion in the healthcare space	Walgreens Medicare ACOs
Disease management companies	Current DM is in decline and this is a new revenue opportunity	Texas Health Resources ACO with Healthways
Management services organizations	Extension of services already offered to physicians; new revenue opportunity	Imperium
Insurance companies	Would like to be able to offer cheaper product in the market to increase market share	Aenta ACS, United Optum, Cigna, BCBS
Insurance brokers	Concerned that less people will be insured through employers and this will impact their revenue model	A private exchange that will offer population health management
Medicare Advantage insurers	Partnering with physician groups to start ACOs as a market expansion strategy	American Health Network; Collaborative Health Systems
Dialysis companies	Would like to expand services to other populations	Davita purchase of HealthCare Partners
Group purchasing organizations	Expand services to be more value-add than just purchasing	Premier ACO Collaborative
Associations	Additional benefit to members	MGMA Ancetta tool
Revenue cycle companies	With less FFS revenue, less need for revenue cycle management; need to branch out into population health management	Accretive Health; MedSynergies

What Is Different This Time?

Although there is a lot of market activity, it certainly does not mean that the market is always correct. There is a healthy degree of scepticism that the population heath business is going to be a fad similar to the managed care push in the 1990s. This point of view has merit, but there are several reasons why managed care failed to take hold in the past that are being addressed in this current movement (see **Table 3**).

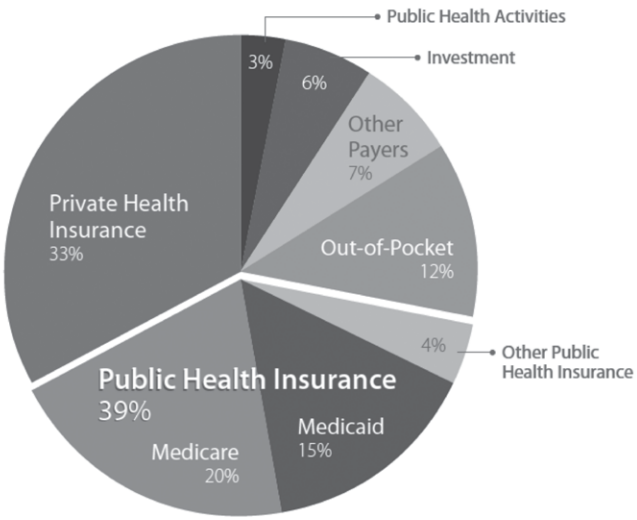
Table 3. Previous Efforts to Manage Care vs. Today's Population Health Approach

	1990s Managed Care	2013 Population Health
Employers	Unemployment rate was low and the focus was how to keep and retain employees with little desire to change benefits	Unemployment high and employers trying to find any way to reduce benefit cost
Data	Most data systems were immature and could not be used to manage populations	Robust population management systems are available in the market
Patients	Did not understand what they were buying into and had no financial incentive to decrease or change utilization	Benefit design gives patients varying options associated with different costs
Payment*	Deals were done to trade off reduced prices in exchange for more volume	Most per-unit payments are the same with opportunities for performance-based increased payment
Key to Success	Create roadblocks to keep patients from using healthcare	Segment patients and provide the ones with the greatest need enhanced, lower-cost services to avoid the need for expensive rescue care

*Payment today is dependent upon local supply and demand for services. In markets with excess capacity, there are movements to have reduced payment for increases in volume.

There is no assurance that by correcting the problems of the past, it will work perfectly this time. Healthcare leaders should anticipate and expect a crop of new issues to emerge that could derail the efforts if they are not properly addressed in a timely fashion. A number of forces are coalescing to ensure that these yet to be articulated issues are managed from the payers that are embracing population health management and migrating their operations to thrive in this model.

Exhibit 1. Who Pays for Healthcare and How Do They Buy It?



Source: California HealthCare Foundation, U.S. Health Care Spending, 2010.

Dual Goals: Rebuild and Reinvent

Examples from the private sector are relevant to healthcare in this transition to value-based care. An important key is to accomplish two major strategic goals at the same time: rebuild the core business while also reinventing the business model. As Clark Gilbert, Matthew Eyring, and Richard N. Foster describe in a recent *Harvard Business Review* article, "Major transformations need to be two different efforts happening parallel. 'Transformation A' should reposition the core business, adapting its current business model to the altered marketplace. 'Transformation B' should create a separate, disruptive business to develop the innovations that will become the source of future growth."[1]

For example, in the 1990s competition from Asia eroded Xerox's margins and market share for its more complicated and expensive copiers and printers. Net losses a decade later approached $273 million. Xerox repositioned its "core" by focusing on a line of simpler, more cost-effective copiers that are more technically advanced and less expensive to operate. Then, it built a new business model by creating the Xerox Global Services Unit, which took over document management and other processes for large organizations. This new business unit accounted for 51 percent of the company's total business by the second quarter of 2012.[2]

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Private Health Insurance Market: An Overview

There are several segments of the private health insurance market that have different dynamics. The market is segmented by individual, small-group, and large-group payer coverage. A vast majority of plans in the group market and a minority in the individual market are purchased through brokers. Brokers, who receive a commission from the insurance company, advise the purchaser as to what coverage would be the best value. This analysis has typically focused on the network discount the insurer has contracted with the providers (hospitals, outpatient services, and physicians).

The individual market is currently small and less profitable for insurance companies for many reasons including a smaller risk pool and market size, and lower market rates. A majority of

1 Clark Gilbert, Matthew Eyring, and Richard N. Foster, "Two Routes to Resilience," *Harvard Business Review,* December 2012.

2 *Ibid.*

the profit for most insurance companies comes from the small-group market, where they are taking insurance risk and administering the plans. In the large-group market, most companies are self-insured and use the insurance company for third-party administrative (TPA) services only. This means that the employer assumes the risk for the medical utilization and the insurance company provides the network and administrative services.

Most hospitals/health systems with over 2,000 employees (approximately 5,000 insured lives—employees plus dependents) are self-insured, and this represents an opportunity for the hospital or health system to better manage this population and receive the immediate benefits. For example, if a hospital were to implement a program that reduced admissions for their employee population, the loss of revenue for these services would be an immediate benefit cost savings to the hospital/system on a full-dollar basis.

Most hospitals/health systems with over 2,000 employees are self-insured, and this represents an opportunity for the hospital or health system to better manage this population and receive the immediate benefits.

Medicare vs. Medicare Advantage

Medicare Advantage (MA) originated with the passage of the Balanced Budget Act of 1997, which offered Medicare beneficiaries this option, instead of receiving these benefits through the original Medicare plan (Parts A and B). These programs were known as "Medicare+Choice" or Part C plans. Pursuant to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the compensation and business practices changed for insurers that offer these plans, and Medicare+Choice plans became known as Medicare Advantage plans.

The main benefit of MA plans is that they can alter benefit design to create a product that is more appealing to certain segments of the population. For example, they may have a less generous benefit for a service that is expensive and rarely used, while offering a more generous benefit for another common service or even covering a service that is not part of Medicare. These plans assume insurance risk and can be considered a form of accountable care organization (ACO). Their enrollment has been growing steadily and they are becoming a formidable force for hospitals to contract with as they may offer reimbursement to hospitals below Medicare rates.

Employers

Employers are the first place to start as they are funding the current payment system. Employer-sponsored healthcare originated as a result of the wage freeze during WWII. Employers wanted to attract and retain the best workers and came up with new ways

to increase retention by offering benefits, which spurned the increase in employer-sponsored health insurance.

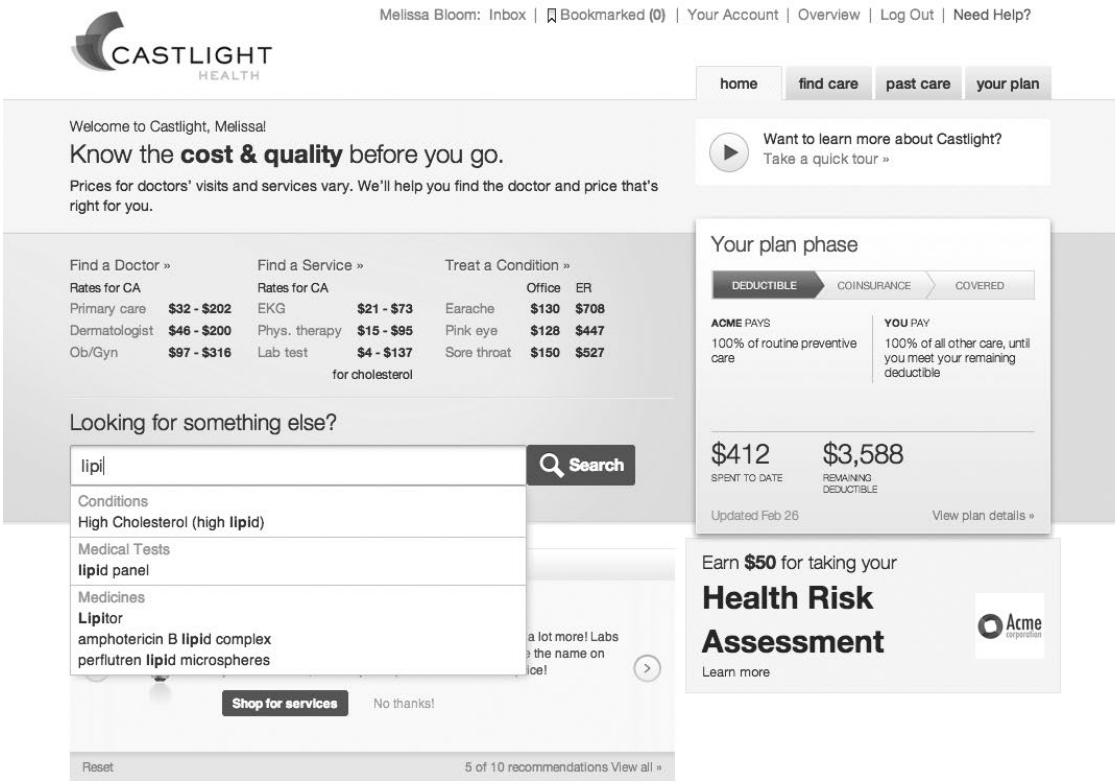
While it is generally agreed that employers cannot reduce benefits without much turmoil, employers have a history of making these changes when there is an opportunity in the market. For example, most employers have successfully moved their employees from a retirement pension plan to a 401K with the employers providing a match. Then during the recent recession many employers suspended the match, and some have taken this opportunity to eliminate the benefit all together.

Employers are now squarely focused on healthcare, and the approaches taken to date have not produced the desired outcome of lower costs. Several employer healthcare trends are notable. First, employers have been cost shifting slowly for several years, resulting in employees being forced to pay a larger portion of the premium. But until recently there has been little incentive to fundamentally change the system.

The increasing trend of high-deductible or consumer-directed health plans has reached a tipping point and is starting to show early results. High-deductible plans have been offered for many years, but people using these products have been frustrated at the lack of information available to make healthcare decisions. Given that there rarely was a need to provide actual price information to healthcare consumers to make decisions, this should come as no surprise.

As more people have enrolled in these lower-premium plans, there has been an increased need to provide data to these consumers so they can make educated decisions. Emerging data are demonstrating that families enrolled in a high-deductible health plan spent 14 percent less on care, on average, than families in

Exhibit 2. Castlight Health Product Offerings



Source: Castlight Health: www.castlighthealth.com.

traditional plans, according to a Rand study of claims data for 53 large employers.[3]

There are also significant efforts in the market to produce actionable information for employees so they can make smarter purchasing decisions once they are enrolled in these high-deductible plans. For example, one commercial company is making substantial investments in this regard: Castlight Health enables employers to introduce innovative, shopping-based benefit designs that engage employees in healthcare decision making (see **Exhibit 2**).

Employers are also looking at other arrows in their quiver to attack the healthcare cost conundrum. Due to local market dynamics, insurance companies are often not able to contract for a given service at a similar price between geographical areas. While this can be beneficial for the local hospital, it has frustrated employers and resulted in two new contracting strategies.

One strategy is the national contracting for select services within a single or very narrow network of providers—larger national employers are looking for a national provider for select, high-cost services. This often involves a contract that is outside of the scope of the traditional insurance system. The employer is creating a direct link to select providers for a specific service and, in doing so, covering travel and other related costs for the employee to travel to the selected provider under the belief that this is a better solution for both the employee and employer.

Lowes is currently under a national contract with Cleveland Clinic for cardiac services, which serves as an overlay to the local provider networks. Patients are offered the opportunity to go to Cleveland Clinic with travel expenses paid for by the company. Walmart has instituted a similar program by selecting six providers across the country in a similar model.

The second strategy likely to gain popularity is reference pricing, in which the employer sets a maximum price for a service and leaves it up to the employee to shop for providers that will provide that service at or below the reference price. Although a patient has insurance, their benefit design will now have an unlimited copayment above the threshold. Thus, even if the hospital has a negotiated price with the insurance company, the employee will now be motivated to shop and travel to a facility that is within the range.

3 M. Buntin, Ph.D., A. M. Haviland, Ph.D., R. McDevitt, Ph.D., and N. Sood, Ph.D., "Healthcare Spending and Preventive Care in High-Deductible and Consumer-Directed Health Plans," *The American Journal of Managed Care,* Vol. 17, No. 3 (March 2011), pp. 222–230.

One large employer that has successfully implemented reference pricing and published results is CalPERS. CalPERS provides retirement, health, and related financial programs and benefits to more than 1.6 million public employees, retirees, and their families and more than 3,000 public employers in California. CalPERS has instituted a number of innovative programs, including reference pricing for generic drugs, select screening exams, and most recently, hip and knee procedures (see **Exhibits 3** and **4**).

An additional underlying trend with employers is focusing on wellness in efforts to increase employee productivity and reduce costs. This is an area of significant contention as the evidence currently available in this field is inconclusive and thus controversial. While intuitively, most would support wellness under the premise that finding a problem early or even preventing the problem will result in better clinical outcomes and lower costs, the evidence for many of the screening tests we perform today shows they actually may cause more harm than good. This is due to the non-specific nature of the tests and the resulting real harm that can be done while investigating the positive screening tests.

Furthermore, many wellness programs are not expected to have immediate results since they are impacting behaviors and it could take years to see the resultant impact on healthcare spending. Employers are embracing wellness publicly as it is synonymous with "mom and apple pie," while behind closed doors they are concerned about the expected outcomes of some of these initiatives.

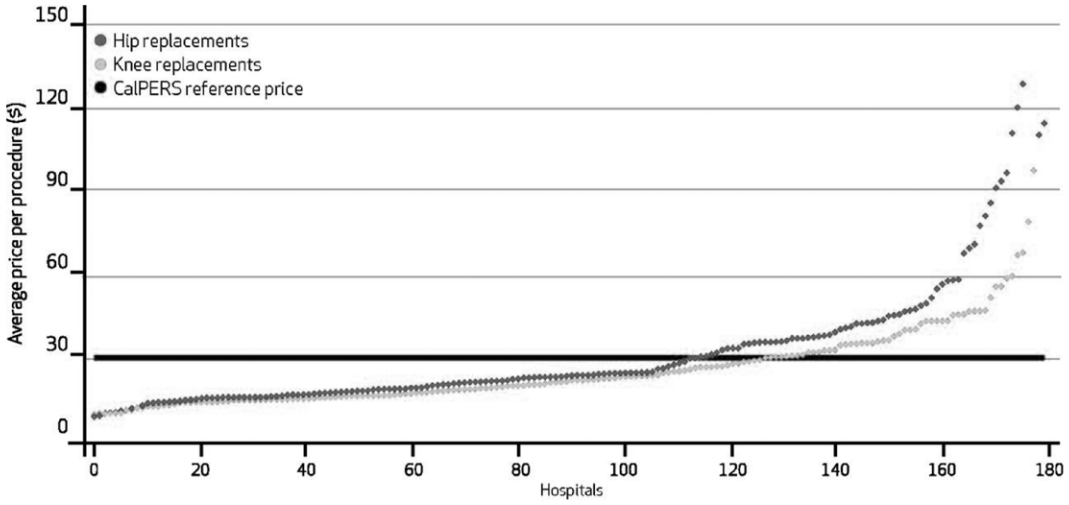
As a result of these trends, some employers are optimistic about the movement to health insurance exchanges. This will enable them to continue shifting benefit costs to employees while also exiting the benefits business. The key question being explored is the notion of a private versus public exchange. The public exchange will likely bring a larger market, but there are concerns about the administration of these markets under government control. As such, there is a movement by the broker community to build private exchanges that will create a market for employees to buy insurance in a controlled environment, while benefitting the brokers. The question remains: will this

Wellness Takes Engagement and Preventive Screenings

There are two components to wellness. One is having employees more engaged in their health and having employers create an environment that promotes employee health. The opportunities in this space are numerous and there are significant outcomes that can be achieved. Programs in this arena include everything from polices to not hiring smokers to changing the food that is offered in the company cafeteria to focus on healthier options as well as displaying nutritional information. Efforts to have employees participate in wellness screening can provide benefits as well, especially when biometric data is used. That being said, one of the best predictors of health and wellness is the employee's own self-assessment.

The second concept of wellness is the preventive screenings offered by the traditional medical providers. This is an area that is far more controversial as the utility of commonly practiced screening tests is being re-examined. This can range from the controversy in PSA testing to regular chest X-rays and EKGs and the annual PAP test as well. The ABIM Foundation (a not-for-profit established by the American Board of Internal Medicine) has sponsored a movement called Choosing Wisely® that aims to promote conversations between physicians and patients by helping patients choose care that is supported by evidence, not duplicative of other tests or procedures already received, free from harm, and truly necessary. This effort has grown to represent over 35 specialty societies and has identified 135 tests that require additional dialogue.

Exhibit 3. Range in Average Price per Procedure across California Hospitals for CalPERS Patients Undergoing Knee or Hip Replacement (2009)



serve as a more efficient market propagator or an opportunity for an existing player to maintain the business?

Brokers

Brokers play a significant role in the healthcare market, and remarkably so with such little visibility into their business. The traditional meaning of the word "broker" in this context is actually a misnomer. Brokers typically are independent agents who receive commissions from an insurer for selling insurance products. Brokers usually work with multiple insurers, and receive different commission amounts from each insurer for selling their product. The cost of the commission is paid for by the plans as an administrative cost that is added to the cost of the insurance.

Many brokers came into the market to fill a void where insurance companies would not sell products to smaller employers due to the high administrative costs. As such, the brokers would aggregate smaller employers into larger groups sizeable enough to do business with the insurance companies. Over time, this model has evolved and the brokers play a key role in advising employers on which insurance plan they should purchase.

Typical commissions range from 2–8 percent of premium, although plans attempting to expand market share tend to pay higher commission rates to encourage referrals. For example, one small health plan in Indianapolis paid brokers a 10 percent commission in a market where the typical commission ranged from 6–8 percent.[4]

Brokers have typically been very focused on performing network analysis looking at the discount an insurance company can offer an employer. This analysis is challenging to perform as many insurers have multiple contracts at different rates with the same providers. The brokers are concerned about small businesses migrating their insurance needs to the public exchanges, which could cut brokers out of the equation. There is a role for a "navigator" to provide advice on the public exchanges that would be compensated, although the remuneration for these services would likely be less than the current state. This is currently a rapidly evolving area.

That being said, the government has a history of poorly implementing larger-scale IT projects and there is likely to be a vibrant role for well-run private exchanges, in which brokers will play a key role. Specifically, the Affordable Care Act (ACA) anticipates this by requiring that the exchanges award grants to "navigators," tasked with educating the public about qualified plans, available subsidies, and enrollment procedures. The National Association of Insurance Commissioners recommends that insurance brokers serve as the navigators and "be adequately compensated for the services they provide." In addition, some private companies have announced their intent to purchase insurance from the private exchanges. Sears and Darden Restaurant Group have moved their employees to one of the private exchanges.

It is interesting to note that the recent experiences of Massachusetts, Sears, and Darden consistently demonstrated that when employees are financially responsible, they choose a lower-cost benefit in which they will bear more of the financial risk. A recent article in *The Wall Street Journal*[5] showed that 39 percent

Exhibit 4. Range of Prices Paid by Safeway for Colonoscopy in Three Markets, plus Reference Price Limit Established in 2010

Source: Safeway Health.

4 Leslie Jackson Conwell, "The Role of Health Insurance Brokers: Providing Small Employers with a Helping Hand," Issue Brief No. 57, Center for Studying Health System Change, October 2002. Available at www.hschange.com/CONTENT/480.

5 Anna Wilde Mathews, "To Save, Workers Take On Health-Cost Risk," *The Wall Street Journal,* March 17, 2013.

of workers selected a high-deductible plan for 2013 vs. 12 percent in 2012. This trend is counter to the conventional wisdom that employees demand and are willing to pay for the best coverage with the least number of restrictions. This is going to then translate into patients wanting more information about the cost and quality of healthcare services and will likely also impact utilization patterns. This represents an important trend in the convergence of patients, providers, and payers all having their incentives aligned for higher-quality, lower-cost care.

Insurance Companies

Insurance companies are the favorite enemy in the healthcare market. That being said, it is important to understand an insurance company's book of business. The ACA has brought about a new level of regulatory scrutiny that is a threat to the insurance companies' business. They now face mandates for a minimum level of coverage, maximum pricing spreads, and profitability. The cost to comply with the mandates will put additional pressure on the business model and the bottom line.

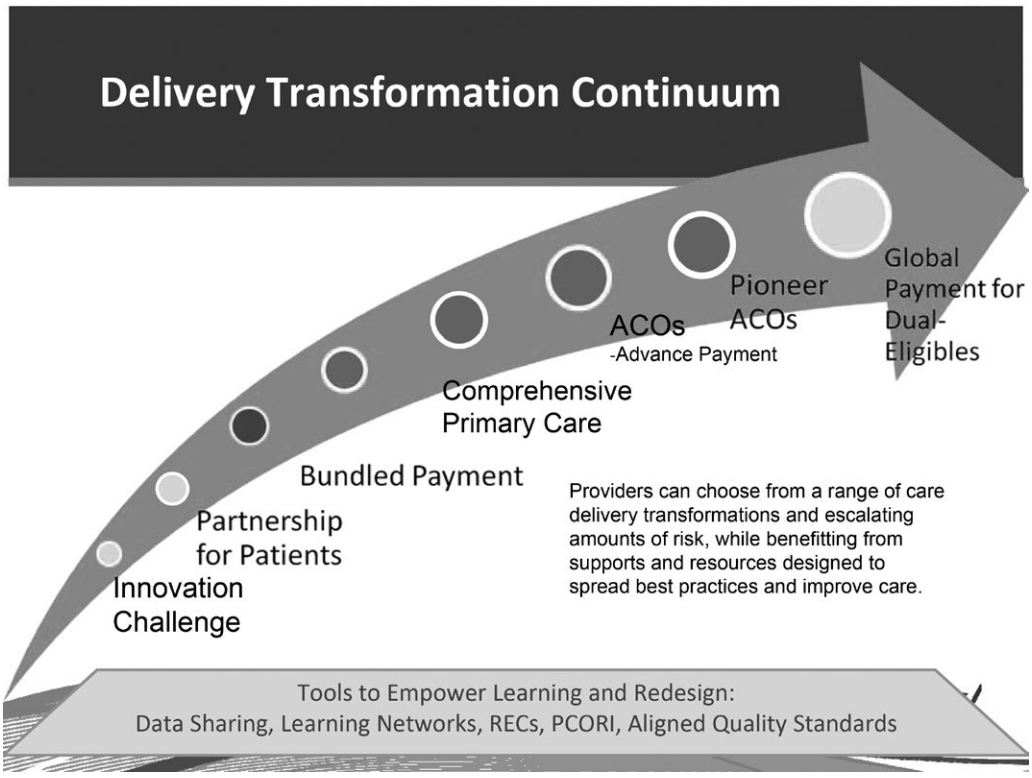
While on one hand, expanding insurance coverage to more Americans is seen as a bonanza, the key question is how profitable the new business will be given the regulatory environment. Furthermore, regional health plans are facing the loss of large business from the larger employers as they are looking for a plan that is the same across the country.

While insurance companies have typically offered case management and disease management, the effectiveness of their programs is being called to question and the market for new industry players to provide these services is growing and expanding. This will apply additional pressure to the insurance companies as the services they provide become commoditized.

Medicare

The Medicare budget is one of the hottest budget items on Capitol Hill due to the wild degree of fluctuation in healthcare utilization. Each time the government identifies an area of opportunity it attempts to alter policy to achieve the intended results, which is a fairly painful process. Ultimately, the Centers for Medicare and Medicaid Services (CMS) would like to have cost predictability, which can only be achieved with capitation. Under capitation, the variables in the equation would be reduced to forecasting the number of people Medicare will cover

Exhibit 5. Delivery Transformation Continuum



Source: Centers for Medicare and Medicaid Services, "Updates from CMS: Value-Based Purchasing, ACOs, and Other Initiatives," *The Seventh National Pay for Performance Summit,* March 19, 2012.

and the monthly price Medicare will pay, as opposed to the complex system that exists today.

CMS is aware that most of the country is ill-prepared to have the insurance risk shifted to them without the management expertise, systems, and process necessary to operate in this business model. As such, CMS plans to develop a number of programs to help build up the skills required for more organizations to succeed in managed care. Hospitals and health systems may find the standard FFS book of business continuing to decline with more payers cropping up in their markets.

Medicaid

Medicaid is a frontier in which very few, if any originations have come up with a sustainable business model. The needs of this population are very different than commercial and Medicare beneficiaries. The primary need is often social in nature including issues such as housing, transportation, and nutrition. Some states have created new programs that have special funding for these social needs in order to reduce the total cost of care. If these programs work, some hospital Medicaid volumes will decline. Since Medicaid generally pays lower rates, this could have a positive impact on hospital financials.

For example, the state of Oregon has created a unique Medicaid "coordinated care organization" program. Each city in the state will have its own umbrella group for caring for the Medicaid population, which will contain hospitals, doctors, mental health providers, and dentists. The idea behind it is that the providers under each umbrella group will no longer need to compete with each other for patients, and there will be an interoperable EHR so the providers can easily share information. The coordinated care organization will be paid with a lump sum to manage a population of Medicaid patients.[6]

6 Kristian Foden-Vencil, "Oregon's $2 Billion Medicaid Bet," Oregon Public Broadcasting, National Public Radio, and *Kaiser Health News*, May 30, 2012. Available at www.kaiserhealthnews.org/stories/2012/may/30/oregon-cco.aspx.

Authentic Care Management

While the problems with the current system are fiercely debated, there is a general consensus that the solution lies in some improved form of care management. The classical care management models have resulted in mixed success for a whole host of reasons, which is why the concept of second-generation care management will be critical for the value solutions.

THE SOLUTION FOR MANY HEALTHCARE CHALLENGES CAN BE solved with better care management. To understand this model, consider the system today: the doctor today is a reactive model. The doctor is trying to deal with all patients who need to come in for reactive care and no thought is given to the patients whom the doctor is not seeing. The goal is about getting through the day and performing as many services as possible. Visits are oriented around the doctor and not the patient, which leads to significant inefficiencies for the patients. In a proactive model, doctors will be responsible for the health and wellness of a defined population of patients, focusing on those most at risk and with chronic disease, and using technology and physician extenders to manage the remaining, lower-risk patients. The goal is to keep patients healthy and out of the doctor's office or hospital, and visits are oriented around the patient. This is essentially a population health approach (see **Table 4**).

Table 4. Reactive vs. Proactive Care Delivery for a Single-Physician Panel of 2,500 Patients

Today's Reactive Model	Tomorrow's Proactive Model
• Doctor sees 20 ppd x 200 days = 4,000 visits a year • Average visits per year for the "average" patient = 3.4 • # of people seen = 1,200 per year (but are they the "right" people? What about the health status of the 1,300 people the practice did not see?) • When patients come in, they commonly do not have the correct tests done prior to the visit; thus the doctor cannot take immediate action. • The doctor also spends a significant amount of time on administrative services for patients that could be performed by someone else.	• Doctor responsible for population of at least 2,500 people and uses a team-based approach. • Everyone gets touched by the practice at the right level of interaction. • Remote monitoring will check on the sickest daily and alert the practice when someone is outside of normal ranges. • Population management software will identify gaps in care for the chronically ill and a scheduler will reach out to them to ensure the appropriate care is performed (based upon protocols). • Lists of patients that are deficient in screening will be created so that before the patients come in for their annual visit, the test is performed with the results available for discussion at the visit.

Tomorrow's Authentic Care Management Model

1. Define the population
2. Segment the population
3. Determine needs by segment
4. Implement programs
5. Measure and refine

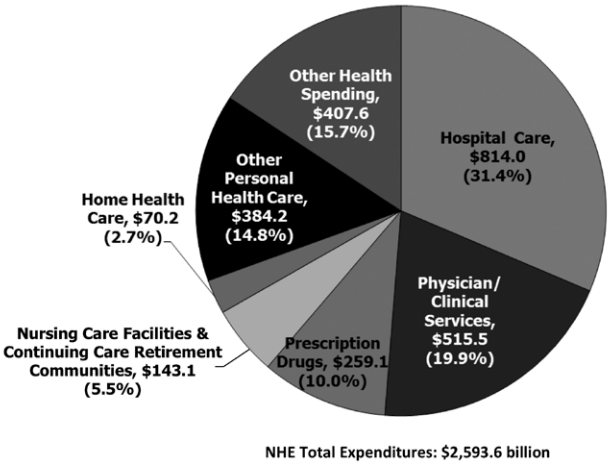
The first step to population health management is to define the population—this is typically a strategic and tactical exercise to determine how patients will be attributed to the program (either by what insurance they have or what physicians they see). This initial selection is typically done by starting with a payer class (e.g., commercial population, Medicare, or Medicaid) and then identifying a sub-population within the class for the population health program. For example, one population that is easy to define (and provides an opportunity for population health management) is the employees and dependents of the self-insured health system.

After the population is defined, the next step is to create a functional segmentation. This will help identify who is currently sick, who is likely to be sick, and who is well. There is no perfect way to do this segmentation and it is often constrained by the data available for the whole group. As such, it is typically performed on claims-based data, which has limited predictive value. Alternatively, clinical data can have good predictive correlations, but is typically more challenging to collect on the whole population.

Cost-Based Segmentation

Once the segments are defined, it is important to determine the needs for each segment. For example, who needs preventive services, case management, disease management, health coaching, etc.?

Exhibit 6. Distribution of National Health Expenditures, by Type of Service (in Billions), 2010



Note: Other Personal Health Care includes, for example, dental and other professional health services, durable medical equipment, etc. Other Health Spending includes, for example, administration and net cost of private health insurance, public health activity, research, and structures and equipment, etc.

Source: Kaiser Family Foundation calculations using NHE data from Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, at www.cms.hhs.gov/NationalHealthExpendData/ (see Historical; National Health Expenditures by type of service and source of funds, CY 1960–2010; file nhe2010.zip).

Population Segmentation Key Questions

- What does the organization want to accomplish?
  - » Critical first step often missed
- Which group(s) of patients presents the greatest opportunities?
- What are the most prevalent conditions in your population?
  - » Acute/chronic
- Who should be managed?
  - » Who are the highest-cost patients/groups?
  - » Who are the patients with acute/chronic condition(s)?
  - » Who are the patients not following treatment guidelines for their condition(s)?
- Is management intensity right?
  - » High-touch, low-touch, technology

Typical Care Management Opportunities Vary by Population

Like any implementation effort, the success of a program is going to hinge more on how it is done rather than the strategy of the program. The key here is having the right people who have care management experience in a managed care environment where they have demonstrated success. Care management systems that are different than the hospital systems need to be put in place, along with the process to operate the program to achieve the desired outcomes.

Biggest Opportunities, by Payer

Commercial
Emergency department
Admissions
Ambulatory surgery
Specialty drugs

Medicare
Admissions and readmissions
Emergency department
Skilled nursing facilities
High-end radiology
Advanced illness planning

Medicaid
Behavioral health
Obstetrics
Complex children
Disabled

Source: Geisinger Health System.

Table 5. Effective Redesign and Care Coordination Delivers Rapid Impact

Activity	Expected Impact	Time to Impact
Effects within Months		
Transitions of care management	Reduce readmissions	3 months
Case management for high-risk patients with targeted conditions: diabetes, heart failure, COPD	Reduce primary admissions and ED	3–6 months
Case management for other high-risk patients	Reduce primary admissions and ED	6–12 months
Pharmacy management	Increase generic use	6–12 months
Effects within 1–2 Years		
Nursing home management	Reduce readmissions/primary admissions	12–18 months
More efficient specialists and ancillary providers	Decrease cost per episode of care	12–18 months
High-end imaging	Reduce unnecessary testing	12–18 months
Effects within 3–5+ Years		
Interventions for low-risk chronic disease patients: disease registries, chronic disease care optimization	Improved control; avoid complications	2–5 years
Preventive care; screening; lifestyle change; wellness	Earlier identification and treatment; decrease incidence of chronic diseases	2–5+ years

Source: Geisinger Health Plan.

Case Example: Scottsdale Healthcare Develops Employee ACO Program

Integrating with Physicians to Share Risk

To prepare for value-based purchasing, Scottsdale Healthcare joined members of its medical staff to form a clinically integrated network organization through a shared governance model. In 2011, when Scottsdale Healthcare senior vice president and CFO Todd LaPorte, CPA, first presented this plan to the system board, he described it as "the riskiest business plan I have shown you over the last 10 years." Then he added, "There is a greater risk if we do nothing."

The network, Scottsdale Health Partners, will elevate the coordination of care efforts in preventive care and other services leading to healthier patients. "We now have an opportunity in sharing the risk and reward of successful clinical integration with our physician partners," LaPorte said. "We recognize one consequence may be reduced hospital utilization. We recognize that this movement is already underway. We can take a community leadership role and shape the process, or we can sit back and just watch it happen to us."

While it is true that the network is embarking on a strategy that carries some risks, every step has been weighed and every risk calibrated. Scottsdale Healthcare took an open-eyed look at its current circumstances, and decided to systematically develop the structure and skills that will be essential for value-based purchasing.

"Our board members are all sophisticated in their own professional worlds," commented Thomas J. Sadvary, FACHE, president and CEO. "They understand that at certain times you may need to invest in something that doesn't have a straightforward, immediate payback. We are literally in a transformational environment now; we have to step out if we want to be a bit ahead of the game."

Scottsdale Healthcare is a three-hospital, 800-bed system serving patients in Maricopa County and south-central Arizona. It has a small group of employed physicians, currently numbering about 15 primary care physicians and 35 specialists. As the system considered options, it determined that instead of just creating a larger network of employed physicians, it would also partner with independent physicians. "We developed this structure together over months of discussions and meetings," recalled Richard Silver, M.D., CMO and vice president of Physician Alignment. "We met every other week with the private physicians who were most interested, trying to determine what governance and work structure would be most effective for us."

Scottsdale Health Partners, founded on June 15, 2012, is a 50-50 joint venture between the system and newly formed Scottsdale Physician Organization. While the three-hospital roster lists about 1,600 physicians on the medical staff, only about 600 are active and actually practice at the hospital. Of those, more than 450 have joined the network.

"A core group of doctors served on the steering committee or various task forces; they were involved from day one," Sadvary recalled. "This heightened their intellectual understanding of the process, and also their personal excitement and commitment. Frankly, that's a major reason such a large number of doctors have joined the network. While hospital executives were obviously part of the conversation, the peer-to-peer relationship is what closed the deal." The network's 50-50 board of directors includes three primary care and three specialty physicians on the physician side, representing Scottsdale Physician Organization, and then six board members appointed by Sadvary, representing the hospital.

For the network to function as planned will require a substantial build-out of information technology, actuarial, and care management services. To avoid burdening the joint venture with heavy initial costs, these services will be housed in a management service organization, wholly owned by the system. The joint venture will pay for these services over time under a management services agreement.

> "We recognize one consequence may be reduced hospital utilization. We recognize that this movement is already underway. We can take a community leadership role and shape the process, or we can sit back and just watch it happen to us."
>
> *—Todd LaPorte, CPA*

Pilot Programs Underway

The integrated network is starting out with a pilot program for Scottsdale's employees and dependents—about 10,000 covered lives. In July 2012, employees were invited to use network physicians, incentivized with a zero copayment for primary care and a reduced copayment for specialists. In January 2013, Scottsdale rolled out a new benefit plan with increased incentives for choosing a primary care physician. "One frightening statistic we learned is that one-third of our employees, even though they work in healthcare, don't have a primary care physician," Sadvary said.

During the initial stage, Scottsdale will roll out initiatives aimed at reducing unneeded ER visits and increasing generic drug utilization. "We know that when a patient forms a relationship with a primary care physician, preventive and periodic testing such as blood sugar levels and cholesterol screening happen more robustly," Silver said. At the same time, he emphasized that this is not a return to the old HMO gatekeeper model. "We focus on the fact that 60 percent of healthcare costs occur outside the hospital. Twenty percent of your patients spend 80 percent of your dollars and 5 percent of your patients spend 40 or 50 percent of your dollars. Therefore, we need to put together interventions to identify high-risk patients and offer increased services, intensive services, to improve their care for chronic diseases such as diabetes and congestive heart failure."

Scottsdale will build a robust care management system, driven by sophisticated data. Clinical nurse specialists, dieticians, and educators will work closely with people who have chronic conditions. Social workers will seek out resources for people who can't afford essential medications, or need transportation to access healthcare services. Care navigators will be available to support those coping with a problem and need access to appropriate information and specialists.

Scottsdale is also developing a health information exchange, a cloud-based data repository that reaches into multiple sources and pulls all the data on a specific patient together in one record. It is a secure Web-based tool that meets HIPAA privacy standards and can be accessed from the hospital, the ER, the physician office—from any secure logon.

Every practice will be able to sign in to the Web-based tool and access a dashboard that lists all patients and highlights gaps in care. Data will be available from health plan billing codes, from lab tests done at national labs and also at the hospital, from prescriptions. "We're going to use a clinical disease registry to drill down through all this data," said Silver. "Starting with our own employees, and eventually with other health plans, we will be able to identify high-risk patients and then give each primary care physician the following two lists: first, people who should have had a certain test at a given time, but haven't had it, and then another list of people who did have the test, and the results were way out of range—they need follow-up."

Access to real-time data is essential for success in these initiatives, Sadvary emphasized. "When we explored information technology, one common theme is that if you want to support physicians in making real-time decisions, you must give them access to relevant data. Unfortunately, many available products are purely retrospective; they only look at what has been done in the past, not at how to help the doctor make decisions now."

Financial Model: Shared Gains

Under the new initiatives, payments will continue on a standard FFS model. In addition, network physicians will receive a care management fee for extra services to help manage patients. Scottsdale will be positioned to enter into "gainsharing" agreements with payers. "One important issue in forming a network like this is how to structure it, so it can weather the early stages of tighter cash flow," LaPorte said. "It needs time before it can generate income. That's why Scottsdale Healthcare Partners plans to take on only upside risk, gainshare risk, during its first three to five years. Over time, as the market changes and as we are ready, then we will consider downside risk."

> "We focus on the fact that 60 percent of healthcare costs occur outside the hospital. Twenty percent of your patients spend 80 percent of your dollars and 5 percent of your patients spend 40 or 50 percent of your dollars. Therefore, we need to put together interventions to identify high-risk patients and offer increased services, intensive services, to improve their care for chronic diseases such as diabetes and congestive heart failure."
>
> *—Richard Silver, M.D.*

Scottsdale's long-term plan calls for seven primary care sites with employed physicians to improve access to care in areas not well served by private physicians. It will transition towards patient-centered medical homes, and it is applying for bundled payments for cardiac and orthopedic care. However, it has decided not to form an ACO at the present time. "ACO defines being at risk with CMS on a Medicare product," Silver said. "Our population is very commercial-based. So we're not going to do an ACO

out of the box, although we might do that at some point further down the line."

Scottsdale's analysis of the local market has determined its basic strategic plan. "You have to understand the physician profile in your specific market, the health plan profile, the employers," Sadvary said. "Since employers ultimately are paying the bill, they are an important constituent group. We're starting to spend more time with our employers, so we can better understand what's on their minds."

The characteristics of the local market also influence the pace of change. "We all know value-based payment in some form is going to happen," said Sadvary. "The key question is, what pace of change will be required for you and your doctors and patients to be successful?" Scottsdale leaders considered this question carefully. "We realized that to hit the ideal pace exactly on target is impossible, so we've made a proactive decision that we want to be a little early to the game," Sadvary said. "We don't really want to be at the cutting edge, but at the next phase of leadership. We want to learn from other, earlier examples, and also get into the game sooner rather than later."

Long-Term Culture Change

Scottsdale is embarking on a long-term process of culture change. It is starting to think "outside the hospital walls" and its key metric is no longer hospital volume. This process will require significant changes from many people who are used to patterns of the past. Under fee-for-service, when a cardiologist does a stress test or an echocardiogram he makes more money. Now the health system is asking cardiologists to practice evidence-based medicine, which likely means fewer sophisticated tests. "We are shifting from a mentality of being paid for each service performed to being paid for the health of a group of people," Silver said. "As their health improves they use less resources, and there is more money left in the system. Eventually the focus will shift to how well the overall network performs, not how 'much do *I* get paid?' But there is a dynamic tension while we are on the journey."

"Five years from now, if we can look at the Scottsdale market and demonstrate that we have improved the health of the population we are serving, that is our goal," Silver continued. "Our care delivery model will facilitate connections between the hospital, the doctor's office, various outpatient settings, and the patient's home. Then we will truly be able to care for patients in a very different way, not just when they are sick, but when they are healthy, finding ways to keep them healthy. We are still in the early stages of this process, but that would be a home run."

Case Example: Baylor Health Care System Develops Various Payer Contracts with Incentives

The Baylor Health Care System (BHCS) in Dallas has been preparing for value-based purchasing since before that term existed. "We know that at some point there may not be FFS any more," said Dianne Grussendorf, Baylor's vice president of managed care. "We may find ourselves responsible for a medical budget. Think of it as the difference between a credit card and a debit card. In the past, the environment made it possible to just spend, spend, spend, utilize, utilize, utilize: just like putting a project on your credit card. In the future, providers may be in a debit-card environment. That means there is only so much money in the account, and after you spend your budget, there is no more money left."

Baylor is a large, not-for-profit healthcare system with more than 100 years of history. It includes 30 owned/operated/ventured/affiliated hospitals with 3,653 licensed beds, plus 193 HealthTexas Provider Network locations, 26 ambulatory surgery centers, 83 outpatient facilities (for imaging, rehabilitation, and pain management), three senior health centers, and more than 21,000 employees.

Baylor's current model is FFS with an overlay of incentives for improved utilization and quality. About 10 years ago Baylor started creating the environment and processes necessary to support value-based purchasing. "That means collecting data, being transparent with your data, and creating an infrastructure to share data and use it to coordinate and navigate care," Grussendorf said.

The Dallas-Fort Worth market has shaped Baylor's choices and priorities; the system still has room to expand. "In Dallas we are blessed to be in a still-growing market," said Gary Brock, COO. The population in the 10-county area is expected to double by 2025. "We can continue to grow, and at the same time do all the right things in terms of incentivizing for quality, reducing length of stay, and so on. For example, we have three hospitals with 30-day readmission rates for congestive heart failure below 10 percent."

The local market has four major payers: Blue Cross, United, Cigna, and Aetna. It is dominated by large, self-insured clients. "We are not an HMO market. We are not a fully insured market," said Grussendorf. "We serve self-insured companies ranging from 50 employees and up. Our payers are the voice of the employers, and they are obviously interested in saving the employer money. However, they realize that you can't save money by simply negotiating lower rates—that would be a very shortsighted approach. Payers recognize that many initiatives on the quality and care delivery side will translate into savings for the employer."

Contracts vary depending on the special interests of each employer. Some are particularly interested in reducing readmissions or emergency room utilization. Some are interested in process measures such as testing hemoglobin A1c levels in diabetics; others are more interested in outcome measures, such as attaining normal hemoglobin A1c levels. "An employer may have particular interests based on their workforce characteristics," Grussendorf notes. "For example, if 50 percent of their workforce

is obese, they may ask us to focus on that problem. That would be fine, since we already know that many patients are obese, and we are already working to develop the most effective programs for that population."

HealthTexas Provider Network

HTPN, established in 1994, is a multi-specialty medical group wholly owned by the Baylor system, which houses all of its physician practice sites. It includes about 600 physicians and 100 mid-level providers such as nurses, nurse practitioners, and physician assistants, practicing in 66 primary care centers and 122 specialty care centers.

Over the years, the HTPN board and the Baylor system board have worked together to develop compensation plans that incentivize better care. "It has not been controversial at all. It has been a collaborative process between the two boards, embracing the idea of raising the bar in quality and satisfaction," Brock said. "Physicians are now putting some skin in the game in order to do that."

> "In the past, the environment made it possible to just spend, spend, spend, utilize, utilize, utilize: just like putting a project on your credit card. In the future, providers may be in a debit-card environment. That means there is only so much money in the account, and after you spend your budget, there is no more money left."
>
> *—Dianne Grussendorf*

For the past four years, HTPN physicians have received a 5 percent compensation incentive for certain quality measures plus an additional 5 percent incentive for patient satisfaction measures. The quality focus is on improving performance on adult health preventive measures such as flu shots, breast exams, and colorectal screening. "When we started working on this issue, our clinics were in the mid-50th percentile in terms of these quality measures; today they are at the 92nd percentile," Brock said.

About three years ago, the HTPN board and the system board agreed to focus on achieving NCQA certification as level-three patient-centered medical homes (PCMHs) for all primary care clinics. At present there are 60 HTPN clinics with 267 primary care physicians and 65 mid-levels approved as NCQA-certified PCMHs. "We think this is important, even though today we're not receiving additional payments for this. It brings into play all the patient-centered standards that you need in order to improve the patient's overall experience," Brock said. "It means we can benchmark how our clinics are doing, and also benchmark them against external examples to see how we can improve." The HTPN board meets monthly, while the system board meets every other month. A review of these initiatives is an important aspect of each board meeting.

Initial Projects Test Clinical Integration and Quality Focus

In recent years, Baylor has embarked on a number of initiatives that are both worthwhile in their own right, and also ways to test new structures, develop new ways of using clinical data, and interacting to improve patient care.

HTPN has over 60,000 Blue Cross patients who rely on its clinics as a medical home. In 2010, Baylor negotiated an initiative to move these patients from brand-name medications to generics, where appropriate. When the program started, 62 percent of prescribed medications were generics; as of June 2012, 72.5 percent of prescribed medications are generics. The program will continue throughout 2013.

In January 2012, Baylor embarked on a project with Cigna to provide more ambulatory care coordination for about 5,000 Cigna enrollees who are in the PCMHs. Physicians will receive a per-member, per-month care coordination fee, which will help pay for health coaches and ambulatory care coordinators. In addition, there are pay-for-performance incentives for physicians based on quality measures for managing chronic conditions such as diabetes, asthma, and congestive heart failure.

An "Ambulatory Intensive Care Unit" is a care delivery model that focuses primary care services on patients with complex, unstable chronic illness. Baylor is working with the Mercer Consulting Group to offer services to PepsiCo employees through an ambulatory ICU project called Care Connect, which started in April 2012. Mercer identified the top 5 percent of high-cost patients with complicated chronic conditions, and these patients are incentivized to choose one of HTPN's patient-centered medical homes. The clinic receives an ambulatory management fee to help better manage these patients, offer more education about their disease process, and help patients become more involved in managing their own condition.

> "Several factors in American healthcare must be improved. We must reduce the overall cost of care and improve the quality of care. In addition, we must clinically integrate what is at present a very disintegrated experience for most patients."
>
> *—Carl E. Couch, M.D.*

Baylor Quality Alliance

In April 2011, the BHCS formed the Baylor Quality Alliance (BQA), a network of physicians, hospitals, and other providers, organized as a limited liability corporation owned by BCHS hospitals. BQA is a voluntary alliance of approximately 600 employed physicians (HTPN), 1,200 independent physicians, and all BHCS facilities. Most, if not all, of the BQA physicians have privileges at BHCS facilities. BQA's mission is to improve quality, reduce the overall cost of care, and clinically integrate care for the patients it serves. Physicians are "participation members" and pay a $1,500 fee to join; however, BQA is a wholly-owned subsidiary of BHCS. The organization is governed by a 19-person board of managers

that includes 14 physicians, three Baylor executives, a community representative, and a BHCS system board member.

BQA started out with impressive goals for high-quality, efficient care, including:

- Best care and quality improvement processes, designed by physicians
- Strong clinical integration across all points of care
- Best population management
- Best HIT and analytical reporting
- Best provider performance reward system
- BHCS-aligned contracting, network development, legal and finance support
- Efficiently reducing rate of increase in the cost of care

"Several factors in American healthcare must be improved," said BQA President Carl E. Couch, M.D. "We must reduce the overall cost of care and improve the quality of care. In addition, we must clinically integrate what is at present a very disintegrated experience for most patients. The Baylor system has heartily endorsed the creation of this organization, has funded it well with a capital contribution, and has committed to a strategy that enables us to align with all willing and qualified physicians in order to prepare us for healthcare changes over the next several years. BQA is an investment in the future."

About 4,600 independent physicians serve on the medical staff at the 30 hospitals in the Baylor system. As of December 2012, essentially all of the employed physicians in HTPN have joined BQA. In addition, more than 1,200 independent physicians have been credentialed as BQA members, over 500 are in the credentialing process, and an additional 700 have expressed interest in joining. "At this time BQA membership is open, and we are accepting independent physicians as well as the employed physician group," Couch said. "Our board has said that at some future time we will probably try to balance our capacity with our demand and close membership in some or all specialties."

In addition to the one-time membership fee, BQA physicians are contributing hours of "sweat equity" to help build the organization and its capabilities, serving on committees that develop best-care protocols, policies, procedures, plans for clinical integration. "This work is voluntary, but during the first four months we probably had over 1,200 physician hours invested," Couch said. "In addition, every doctor who joins the organization will invest sweat equity in terms of adjusting their practices and their office routine, training their own staff to follow new procedures, clinically integrating care within our network, reviewing their own performance reports, and so on."

In January 2013, BQA became the preferred provider network for Baylor's self-insured medical plan, which covers 20,000 employees and 12,000 dependents. The plan design relies on a copayment of 10 percent to incentivize employees to choose a BQA physician. Aetna physicians in a broader network will also be available, with a 35 percent copayment. Elective surgeries done at a Baylor facility will have a 20 percent copayment, while those who go outside the system will face a 50 percent copayment.

"We are creating a streamlined network with best-practice protocols. Our physicians are all connected with an electronic record to the hospitals and to each other, so that we can better manage information flow and patient care," said Brock. "We're sharing data with providers so they can improve. We think we are offering higher-quality care for our employees and their dependents, and we want to incentivize them to choose this plan, not force them."

BQA will use registered nurses as health coaches to work with sicker patients, who account for the bulk of healthcare spending. It will develop initiatives to target areas where evidence-based practice can improve clinical quality, improve the patient's experience, and cut costs.

"Next year we plan to work on avoiding advanced imaging services for patients who do not need them," said Couch. "For example, according to current evidence-based best practices, patients with uncomplicated low back pain do not need an X-ray or an MRI. Instead you need to relieve the person's symptoms and get them into a therapy program that will get them well."

Physicians will have an opportunity to review their own data and see how they compare to benchmarks. "We'll probably measure things like how frequently a physician used X-rays for a given condition, and compare them to everybody else," Couch said. "Maybe you have 100 X-rays for 100 patients, but the average for your peers was 20. We would show you your data. We would sit down and have a conversation and review the reasons for the protocol."

BQA considered but decided not yet to pursue designation as a Medicare ACO. "Baylor Quality Alliance is our clinically integrated model, which is similar to an ACO," said Grussendorf. "Our goals are virtually identical to those of the MSS ACO model: that is to improve quality for all patients, to reduce the overall population cost of care, and reduce the rates of rise of costs by clinically integrating care at all levels. Extensive data collection is a vital driver of our own performance, and physicians are required to access and review their data on our Web site at least eight times every 12 months."

In addition to serving its own employees, BQA is actively pursuing additional Medicare Advantage and commercial-insurance contracts. In late 2012, the Baylor system and BQA signed agreements to provide coordinated care for Aetna and Humana Medicare Advantage members.

"While everybody talks about clinical transformation, basically we are looking at cultural transformation. We want to alter the model so physicians work at the highest end of their medical license. We want them to become team leaders who work with mid-level providers, ambulatory care coordinators, health coaches, and community health workers. To succeed at this work, you must have committed physicians to help drive the change."

—Gary Brock

Access to Patients Most Significant Incentive

The financial incentives in Baylor's agreements vary, but generally speaking, these are relatively small amounts. "Our doctors and our hospitals are interested in any incentive, since it is over and above fee-for-service," Grussendorf said. "We are not willing to give up fee-for-service reimbursement in exchange for an incentive reimbursement. At the same time, we recognize that fee-for-service reimbursement is going to go down, because utilization is going to go down."

At the same time, Couch noted, forming an integrated system has essential advantages that go beyond specific payment amounts. "At the end of the day the real advantage to this, for the physician, is to be part of a network, because that is where patients will be. If we produce better value (which means high quality in relationship to cost), the market will reward us with patients. Or to put it from another viewpoint, if you're not in the network there are some patients you're not going to see. However, as reimbursement models move from pure fee-for-service to payment for outcomes, and degrees of financial risk, the clinically integrated model and competencies that we are constructing in BQA will become vital for the success of the entire Baylor Health Care System."

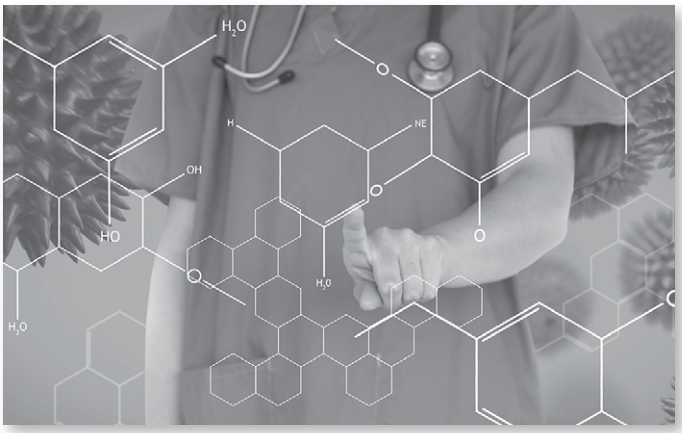
Change Is a Process—What Is Essential for Success?

Data collection is key to success in these initiatives, Grussendorf said. "It is all data-driven. We have to have patient satisfaction data. Quality measures. Financial measures. If you can't measure it, then you don't know."

Brock agrees, but takes the thought a step further. "Information is important, but it is an enabler," he said. "While everybody talks about clinical transformation, basically we are looking at cultural transformation. We want to alter the model so physicians work at the highest end of their medical license. We want them to become team leaders who work with mid-level providers, ambulatory care coordinators, health coaches, and community health workers. To succeed at this work, you must have committed physicians to help drive the change."

Baylor has established an 18-month program with the Cox School of Business at Southern Methodist University in Dallas in advanced management in healthcare. The system identifies physicians with a natural inclination towards management, and offers them scholarships to work for an M.B.A. At this point, 150 physicians have completed the Cox program, and about a dozen have achieved an M.B.A. Those physicians are now in key leadership roles in the system, helping to drive the cultural transformation.

George McClesky, a Baylor board member and BQA board member, believes the business training has been particularly valuable. "I can relate to this issue as an independent professional," he said. "When I was first practicing law I didn't really have a good feel for the business world, and I think physicians tend to fall into that category, too. They practice medicine, they're scientists, they think analytically. Based on their training, they aren't driven by the same data points as hospital administrators. The program at Cox educates them about business issues, and I think this insight has been particularly helpful in this situation."



Smart Strategies for Providers to Interact with Payers

Healthcare is still a local business and as such it will be critical for providers to understand their local market dynamics in order to select strategies that will bring them success. All providers will need to address a fundamental question, either actively or passively: what are your aspirations with your payers? This can range from simple to fairly complex arrangements. Different strategies will be relevant depending upon the provider organization's aspirations and roadmap.

Questions to ask before starting a health plan:

- What is the goal of this strategy and is the health plan necessary to achieve this goal?
- What are the state licence and capital reserve requirements?
- How will the hospital/health system build the infrastructure to run a plan quickly and competently?
- Could the hospital/health system achieve the same goals via a partnership with an existing health plan or by purchasing an existing plan?

On the left side of the "complexity to implement" continuum as illustrated in **Exhibit 7**, one approach is to continue with the current business model in an "as is" environment. This may work is some select markets (especially rural markets where there is only one acute care provider within a reasonable drive). However, this is not considered to be a viable long-term strategy for any provider, regardless of market environment. It is likely that hospitals that are able to operate at a lower cost structure will be able to convert this advantage into contracts that result in an increase in volume creating the "volume to value to volume" loop.

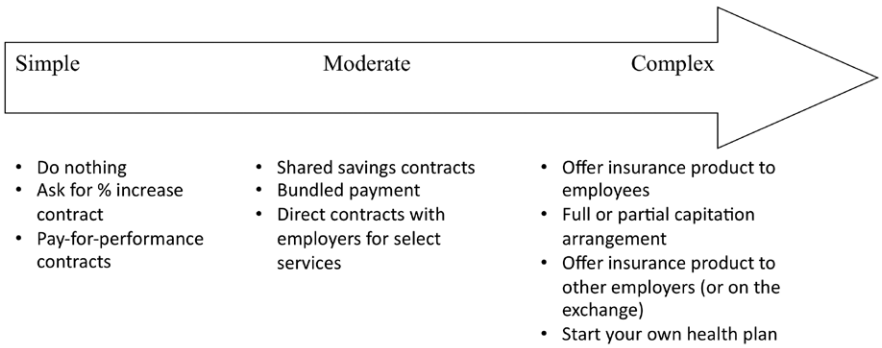
That being said, a competitive threat exists from independent physicians who could organize alone (without the hospital/health system) with the assistance of a third party that has not traditionally been in the healthcare delivery space (e.g., Walgreens, some MSOs). Also, it is important to note that this strategy may work more effectively than a hospital-based ACO to reduce total costs.

The next simple strategy to implement is pay-for-performance (P4P) contracts. These contracts tie rate increases to objective performance measures. Many of these metrics are process rather than outcome measurements, which can bring about criticism regarding the utility of measuring something that has an unproven impact on care. However, there is value to learning the tools and process while better units of measurement evolve. Furthermore, there are some process measurements that have been linked to outcomes.

The next, moderately complex to implement stage of contracting involves shared savings, bundled payments, and direct contracting with employers. At first glance, bundled payment may appear to be simple given that it has a narrow scope using a defined clinical service or DRGs. In reality, it has more complexity in administration than most shared savings programs. Depending on the specifics of the program, bundled payment can require the hospital to actually divert a specific subset of claims to its own TPA and then be responsible for adjudicating the claims, including payment on a service-specific basis.

In contrast, a shared shavings program does not usually involve specific claim-related systems or competencies. Depending on

Exhibit 7. Complexity to Implement



the specific program, most commonly the payer will look at an aggregate cost of a population compared to a benchmark and distribute a single lump sum payment, if there are savings. Many of these programs still operate under the FFS structure and the claims are still managed by the payer. Assuming the hospital is the contracting vehicle, it would be responsible for disbursing the shared savings to the group members for this single payment.

ACO Terms

An accountable care organization (ACO) is characterized by a payment and care delivery model that creates incentives for improvements in quality and reductions in the cost of care for a population of patients. A group of healthcare providers forms an ACO (a hospital does not have to be part of this group for the Medicare or commercial ACO programs). The ACO may use a range of payment models: capitation, fee-for-service with asymmetric or symmetric shared savings, etc. The primary difference between the government and private ACOs are the terms of the programs. For example, in the Medicare ACOs, patients retain the choice of going to any provider, which is a significant disadvantage to the providers and the ACO. Many private ACOs utilize limited or value-based networks of hospitals and other providers to ensure that patients access high-quality and lower-cost care. Other main points of distinction include how patients are assigned or attributed to the models, what data are available and when, and the financial terms of the savings or risk sharing. Many organizations believe the commercial market is offering more favorable terms than the Medicare programs.

There are some limited examples of employers directly contracting with hospitals for select services. These types of contracts can actually be fairly straightforward to implement, as it is similar to adding another payer. Often the contracts will have some special features regarding what is bundled in the services, adding minor complexity. These contracts are rare and not expected to be a large component for most hospitals.

There are several models that are more complicated to implement, but can have a dramatic impact on the future strategy and operations of an organization.

Most hospitals and health systems are large enough to be self-insured, which means that the insurance company does not assume the medical underwriting risk as it is responsible for the network and administration, and the hospital pays the insurance company a fixed fee for this service. Hospital and health system leaders can begin developing a population health management program by starting internally with their own employees and dependents. Since hospitals are already at risk for this expense, any savings can directly accrue to the bottom line. This strategy can be called an employee and dependent ACO. Furthermore, it does not require as many contracting changes in comparison for what is required to take risk with other populations.

The next option for hospitals and health systems is to take full or partial capitation for a population (other than or in addition to their employees and dependents). This requires many skill sets most hospitals do not have including actuarial, case management/care management, networking, and contracting as well as the ability to administer the plan/TPA functions. Receiving this type of payment is very different than offering it.

Another option is to offer an insurance product to other employers (or on the exchange). This will also require the full complement of health plan functions. The next question is how to gain health plan capabilities—build versus buy, or a hybrid approach.

Most hospitals will want to get the same type of contract from all payers, while payers will prefer unique contracts to differentiate in the market.

In general, the smart strategy when dealing with payers is to determine how to get closer to the premium dollar while mitigating risk shifting. The traditional percentage-increase contracts are generally accepted to be a thing of the past (although there are scattered reports of some organizations still trying to get these contracts). The more sophisticated organizations are starting with P4P contracts and then migrating to risk-based contracts.

Another factor to consider is the possibility of developing an all-payer solution. Programs that are payer specific create a number of scaling challenges. Often the population with one payer is not large enough for a long-term solution. In addition, the operational realties of either having to treat different populations with payer specific tools and protocols, or only offering a program to a subset of patients, is challenging from a provider's point of view. That being said, the payers prefer to have a program that is unique to them to differentiate in the market, but they do understand that the all-payer solution is a better long-term solution.

Case Example: Hoag Memorial Presbyterian Creates Commercial ACO Pilot Program

Triple Partnership Explores New Territory

California has a reputation as a place where national trends get started. This has certainly been true in healthcare: California is the place where managed care was invented and managed care organizations retain a strong presence in the state. So as California hospitals move towards value-based purchasing, they start from a different position, compared to hospitals in other parts of the country. "We are doing accountable care 2.0 or 3.0 here, and doing it well," said Richard Afable, M.D., M.P.H., president and CEO of Hoag Memorial Hospital Presbyterian in Orange County.

Another factor that makes California different from the rest of the country is the legal status of physicians. Many hospitals nationwide are preparing for value-based purchasing by increasing their number of employed physicians. However, under California law, hospitals are not allowed to employ physicians. The well-known Kaiser Permanente HMO model does rely on employed, salaried physicians, but these physicians are

employees of the Permanente Medical Group, not of the Kaiser hospitals.

Hoag Memorial is a not-for-profit regional healthcare delivery network that treats nearly 30,000 inpatients and 350,000 outpatients annually. It includes two acute-care hospitals with 579 beds, five urgent care centers, and seven health centers. Early in 2012, Hoag Hospital, together with Blue Shield of California and Greater Newport Physicians IPA, announced a three-year accountable care initiative designed to provide integrated, high-quality and cost-efficient healthcare to approximately 11,000 Blue Shield HMO members in Orange County. This initiative started on July 1, 2012, and will continue for at least 36 months. The partnership's goal is to put the partners at risk to manage cost for employers and HMO members.

"As a California hospital, we have been involved in managed care risk for many years," says Afable. During that time Hoag has been working closely with Greater Newport Physicians (GNP), a 500-physician independent practice association. "This is a common pattern in California," Afable said. GNP was initially established by doctors on staff at Hoag Hospital; today, many GNP physicians have offices within Hoag Hospital's satellite health centers.

Hoag has a long history of managed care contracts, both fee-for-service and capitated. "What's different now is that the risk is shared," Afable emphasized. Hoag has created a three-way, shared-risk commercial ACO pilot program with GNP and Blue Shield of California. "All three organizations are attempting to improve care further by cooperating in the provision of care," he said.

Historically, managed care has emphasized gatekeepers who control access to care and services. "That will not work in the future," Afable said. "If you ration care, it's going to cost you big time. The way we make money now, from the business side of things, is by taking excellent care of patients." This means not just keeping healthy people healthy, but also keeping people with medical illnesses out of the hospital and healthy at home, he adds. "When someone has diabetes or chronic renal failure, you want to make sure they get *all* of the care they need. In the past, managed care might aim at minimizing services. The future is all about optimizing and maximizing outpatient services so that patients never, or rarely, need hospitalization."

A Collaboration for Learning

The Hoag/GNP/Blue Shield ACO's main focus is learning ways to identify unreasonable costs and find ways to reduce costs while improving care. "We are learning how to work collaboratively so that we can create a new product in the marketplace that will be capable of both improving care and reducing cost. Our purpose is not just to care for 11,000 people; our purpose is to learn how to work together," Afable said.

Since this is a new relationship for all three participants, they don't know what they will learn, or where they will find the best opportunities for improving care while cutting costs. "I would suspect most of our opportunities will probably mean direct involvement in relationship management and care management with individuals who are high users of healthcare services," Afable said. "We know that most healthcare dollars are spent by the 10 percent of people who are most ill and have substantial problems. We are going to explore innovative approaches with these patients."

This might mean patients spending extra time with the physician, or with a nurse educator, or having home visits from specially trained nurses. "There's a local company in southern California called CareMore that has done a terrific job at improving care for the sickest elderly with a dramatic reduction in costs, using very basic methods," Afable said. "For example, if you fit elderly people with good shoes, that prevents falls. If you can prevent a hip fracture, you're keeping people at home and out of the nursing home."

Afable expects to see revised, more realistic expectations for end of life. "In the old world view, even if a patient was expected to die, we would still do everything possible to keep them alive, because we got paid for that. If you go to the other side of the coin and ration care, then you have disgruntled patients and families. A more rational approach will start the discussion early and set reasonable expectations about maintaining the greatest possible quality of life when someone has a terminal illness. When this is done successfully, it is a win for everybody."

Sharing Risk, Sharing Data

Success in the Hoag/GNP/Blue Shield accountable care model depends on identifying and removing unnecessary cost from the delivery system, not on shifting risk to other participants. All three organizations will share the upside and also the downside.

Under the new initiative, Hoag and GNP will have increased access to claims data. "This is the first time Blue Shield has been willing to share that data with us, and the reason is that now we have shared risk," Afable said. "We are all in this together. Now that we will share full and complete data on the population we are caring for, we can together, all three organizations, create methods that will maintain the highest level of care and quality to these enrollees while using innovative means to reduce the overall cost, or hold the cost flat."

"In fact this is one of the most important components of the program," said Steve Shivinsky, Blue Shield of California's vice president for corporate communications. "By sharing claims data with providers, we allow for a different kind of collaboration and conversation among those that are assuming risk. We can pinpoint areas where improvements can be made at a diagnostic level, not only to save dollars but also to improve quality."

For example, a joint team that included representatives from Hoag, GNP, and Blue Shield conducted a detailed analysis of claims data to identify joint objectives and savings targets. One project focuses on reducing rates of elective primary cesarean deliveries, relying on evidence-based patient education, informed consent information, and contracting incentives. A drug management project focuses on reducing unnecessary prescriptions, and trying to shorten the lag time in movements from brand-name to generic medications.

In this arrangement, the participants have negotiated varying risk levels depending on each partner's ability to influence specific aspects of care. For example, the physician group has a

greater share of risk related to medication use, since they write the prescriptions. Blue Shield has a greater share of risk related to mental health services, and Hoag has a greater share of risk related to hospitalization and the costs of hospitalization.

In addition to sharing data, Blue Shield is also willing to share the expertise in care management and customer-relations activities it has developed over time. "This is something [Blue Shield] never shared before, but because we now have shared risk we are actually working collaboratively," Afable said.

At present Hoag has some patients in the ACO, some in traditional managed care, and some in fee-for-service. Culturally it can be challenging to have the three approaches functioning side by side. "From the fee-for-service viewpoint, a patient in the hospital is called revenue," Afable said. "A managed care patient in the hospital is called an expense. If the hospitalization is appropriate, the population health approach calls it good care management. So at present we have three things happening simultaneously."

> "Know your own circumstances; base your actions on your own situation and environment. Know where you are and the reasons for what you are doing, as opposed to just following what someone else may be doing in very different circumstances."
>
> *—Richard Afable, M.D., M.P.H.*

Forward-Thinking Board Focuses on Population Health

For several years, the Hoag board has been very focused on population health and on new business development. "Another way to put that is to say that they know we must get out of the hospital business and move towards being a healthcare organization with a focus on population health," Afable said. "The board has been driving us as an organization, for at least five years, to diversify what we do. This serves the hospital's mission, and it is also a realistic, pragmatic approach that recognizes the business of being solely a hospital operator is not sustainable."

The Hoag board has been driving the agenda from the beginning, Afable said. "The board leadership is very forward thinking, so we've been heading in this direction, full speed ahead. And that relates to the fact that we have been in population health for 20 years. We have been in a managed care HMO model. Now that model is evolving, and so we are evolving along with that change."

However, he adds that the view from other regions of the country may be very different. "Know your own circumstances; base your actions on your own situation and environment. Know where you are and the reasons for what you are doing, as opposed to just following what someone else may be doing in very different circumstances."

What circumstances are needed to create success in these initiatives? The most essential factor "is trust between the parties so they work collaboratively to achieve the common goals," Afable said. And what does it take to establish that trust? "Success. Nothing builds trust like success."

Case Example: EMHS Becomes CMS Pioneer ACO

EMHS (Eastern Maine Healthcare Systems) has prepared for value-based purchasing over the past several years, developing an innovative medical plan for the system's own employees. So the system was ready when, in December 2011, EMHS was invited by CMS to become one of 32 Pioneer ACOs serving Medicare patients. "We know the current healthcare delivery system is too fragmented and expensive, and isn't providing the results our patients deserve," said M. Michelle Hood, FACHE, EMHS president and CEO. "We have national benchmarks and quality indicators that are much better than they were 10 years ago. We have clinical information technology and great providers who want to offer a coordinated care model for their patients. The Pioneer ACOs are a learning community that will help us find a way to transform the way we deliver healthcare."

EMHS is an integrated regional delivery network serving the northern two-thirds of Maine and more than 40 percent of the state's residents. The system includes seven member hospitals with 729 licensed acute care beds, as well as skilled nursing and rehabilitation facilities, a broad network of home care and hospice services, emergency transport services, and 42 primary care sites. The system also has a "for-profit" arm, Affiliated, which offers medical support services to both member and nonmember organizations, including laboratories, retail and clinical pharmacies, medical equipment repair, medical supplies, and Web site development.

Initiatives EMHS embarked on several years ago have led to and supported its recent initiatives in population-based care. A decade or so ago, when the system was still in its infancy, the board recognized that the best way to deliver quality care for people across central, eastern, and northern Maine was to develop a regional integrated healthcare delivery system. The system was born from two Bangor-based hospitals, and has evolved to include other member organizations throughout the region, and more than 8,000 employees.

Innovative Plan Design

EMHS' first move toward population-based care started several years ago, with its own employees, who make up about 11,000 covered lives. Its first step was modifying the system's medical plan design to offer an annual online risk assessment for all adult members, followed by individual feedback on ways to lower lifestyle-related health risks. The most attractive insurance options were available only to those who choose to participate in the risk assessment, and there were additional incentives based on premium cost pricing.

The next year EMHS rolled out additional incentives for people who were aware of their own key health-related statistics. The following year employees were incentivized to have a primary care physician. "The idea was that when all of these factors are combined, people would enter into a preventative and wellness-oriented approach with their primary care physician," said Hood.

Blue Shield of California ACOs Rely on Global Budgets

In January 2010, Blue Shield of California, together with Hill Physicians and Dignity Health (formerly Catholic Healthcare West) launched an ACO to serve more than 40,000 California Public Employees Retirement System (CalPERS) members in the greater Sacramento region.

"As a not-for-profit insurer, we have a responsibility to think creatively about how to deliver quality care at an affordable price for as many Californians as possible," explained Steve Shivinsky, Blue Shield of California's vice president for corporate communications. "The status quo was clearly unacceptable. Our projections showed, for example, that based on typical cost increases the average CalPERS family could be faced with an annual premium in excess of $30,000 by 2020. That is obviously unsustainable."

The model for the Sacramento pilot ACO relied on a global budget with shared risk layered atop existing payment mechanisms to align incentives among the three partners. The global budget target means that at the end of the year, if expenses are higher than planned, the health plan, hospital, and physician group must each write off those expenses. However, if expenses are below the target, all partners share in the savings.

The process wasn't easy. Blue Shield started discussing the pilot program with its partners in 2007. Because this was a radically new approach, senior leaders from each of the organizations were personally involved in the effort. "It took over a year just to get everyone on the same page in agreement on the risk sharing arrangement. Then we had to have it all reviewed by the attorneys," recalled Shivinsky. "Our initiative certainly predated the Affordable Care Act and what is now called an ACO. It has been a long time coming."

All the CalPERS members in the pilot ACO used physicians from Hill Physicians Medical Group, and about 75 percent of their inpatient services were obtained through Dignity Health, so that gave the project its critical mass. One essential feature of the global budget model, said Shivinsky, is that it is based "on risk sharing, not risk shifting. Any savings are guaranteed to be credited to the premium. As a result of this approach, providers, hospitals, and physician groups find that they are not only able to accept risk, but they also see immediate results translated into lower premium costs."

The partners conducted an exhaustive analysis of factors driving healthcare costs, particularly among the 5,000 chronically ill patients who accounted for 75 percent of total healthcare costs in the ACO population. A team drawn from all three organizations developed five key strategies:

- Improve information exchange
- Coordinate processes such as discharge planning
- Eliminate unnecessary care
- Reduce variation in practice and resources
- Reduce pharmacy costs

These strategies led to specific initiatives such as new computer tools to share clinical information, shifting non-emergency visits from the ER to urgent care clinics and primary care providers, pre-surgical checklists for patient calls before procedures, coordinated pre-and post-discharge planning processes, and home-based care for frail elderly patients.

At the end of the first year of the program, an independent analysis found ACO per-member costs were 10 percent lower than for northern California CalPERS members who were not in the pilot program. During the first two years of the Sacramento ACO program, the compound annual growth rate in per member per month costs was about 3 percent, or less than half the rate at which premiums had risen over the past decade. These results were due in part to declines in inpatient days and in readmissions within 30 days of discharge.

After observing the success of the Sacramento pilot ACO, Blue Shield decided to expand into other parts of the state. In 2011, it initiated two ACO agreements with providers in San Francisco to serve members from the City and County of San Francisco: the first with California Pacific Medical Center and Brown and Toland Physicians, and the second with Dignity Health, the University of California San Francisco (UCSF), and Hill Physicians. In 2012, it added the collaboration with Hoag/GNP plus four additional ACOs, for a total of eight ACO projects currently serving more than 130,000 HMO members. "We are discussing additional ACO projects for 2013, and our goal is to have at least 20 ACOs in operation by 2015," Shivinsky said.

"While this model and framework is not a silver bullet to solve the affordability crisis, we find that it is clearly working," he noted. "We continue to find additional providers that are willing to assume this risk with us, and we believe this demonstrates that this model has a positive future."

During the same time period, EMHS introduced several workplace wellness initiatives, including offering healthier food in the cafeterias, installing gyms or walking trails at many of the work sites (or discounted memberships at local gyms), and spirited wellness-related employee competitions.

While Maine covers a large geographic area, in social terms it is a relatively small state with an engaged business community interested in innovative health insurance approaches. As large employers heard about EMHS' evolving plan design with its own employees—and its demonstrated results—they expressed interest in similar programs. "We have been in discussions with several large employers about introducing similar design elements to their plans," Hood said. "Large, commercially insured companies have national, third-party administrator (TPA) contracts to manage claims and provide other services. We're working with them to try to introduce this wellness/health literacy approach into their employee healthcare. They have expressed interest in introducing value-based plans designed for their employees and dependents, and we are suggesting that these approaches will yield improved results."

Bangor Beacon Community

Through this work with its own employee base, EMHS tested approaches and tools that it can now use effectively in a wider arena. In April 2010, EMHS was one of 17 communities nationwide to be awarded a three-year federal Beacon grant. The $13 million grant allowed EMHS to build the Bangor Beacon Community, an innovative relationship among a wide range of health providers in the region. Work has centered on promotion of health information technology infrastructure, exchange capabilities, and coordinated care delivery to high-risk, chronic disease populations.

Maine already had a health information exchange (HIE) called HealthInfoNet, which gathers data such as prescriptions, lab results, and allergies. At the start of the project, Eastern Maine Medical Center (EMMC) was the only Bangor organization feeding data into HealthInfoNet. Then Bangor Beacon Community extended access to the HIE and secured email to include eight community partners that provide nursing home care, home health, hospice, mental health, and other services.

More than 1,300 patients are enrolled in the project, and it has demonstrated success on many important healthcare measures. For example, between 2011 and 2012 the hospital readmission rate for congestive heart failure at EMMC was reduced by more than 40 percent. Among high-risk/high-cost patients who had completed six months of care coordination, emergency department visits dropped from 41 percent to 26 percent, and inpatient admissions dropped from 37 percent to 21 percent. Between 2010 and 2012, control of LDL cholesterol among patients with heart disease increased from 57 percent to 66 percent.

Large employers have been impressed by the success of the care coordination model, and it has increased their interest in future opportunities to apply similar principles in managing care for their employees.

The EMHS Difference in Care

Although the Bangor Beacon Community grant ended on March 31, 2013, the work supported by the grant serves as the foundation for EMHS' accountable system of care. Recognizing the value of this work, the EMHS Pioneer ACO has been organized within a newly formed EMHS subsidiary company, Beacon Health, LLC, although EMHS patients will know this effort simply as the EMHS Difference in Care.

The ACO at EMHS initially focused on Medicare patients who used primary care providers at three EMHS hospitals. In 2013, this model will also be standard at the other system hospitals, along with a number of contracted non-EMHS hospitals and Federally Qualified Health Centers (FQHCs). Additional conversations are underway with employers and others in the area to expand the ACO's reach to commercially insured non-Medicare populations.

The decision to participate in the Pioneer ACO program resulted from years of careful thought and discussion at all levels of EMHS. "Years ago, when CMS first began to talk about population health management and an eventual demonstration project in this area, we started to talk about whether we could be competitive in that model. The more we learned, the more we felt we had all of the essential elements in place to be successful," Hood said.

At the same time, it was not an easy decision. "This is a totally different reimbursement model, and entails a tremendous amount of change across the system," said Hood. "It is particularly challenging for small community hospitals that are trying to fit in and contribute to a regional healthcare delivery system. We did extensive due diligence, and the board was well informed and supportive. Our leadership council, which includes the CEOs of all our hospitals and major divisions, sent recommendations to the board supporting this initiative."

The ACO model is very different from the managed care efforts of the 80s and early 90s, Hood emphasized. "HMOs were really seen as blockages to the care delivery process," she recalled. "There is nothing in the Pioneer ACO design or the care coordination design that is intended to restrict access. There are no requirements for preauthorization."

One issue for all organizations moving toward innovative care delivery systems and payment relationships is how to handle the transition period. "The trend is away from fee-for-service, and that is fine," said Hood. "There will always be carve-outs for high-end services such as transplants, but on the whole, the ACO model incentivizes community-based preventative services that take advantage of all the healthcare disciplines, reward quality outcomes for patients, and remove the tendency towards duplication and waste that is currently so prevalent."

During its first six months of operation, the EMHS ACO experienced a 2.9 percent reduction in costs, compared to costs for the same population over the previous three years.

The ACO is acting as a catalyst to highlight essential changes needed in the way we deliver care. "As a system, we must determine how to get as much value as possible out of all our assets," Hood said. "We have to become more efficient." EMHS is investing in telemedicine, care coordination, and home health monitoring, as well as mental health and behavioral medicine services embedded in primary care. "As a result, people with congestive heart failure or asthma or hypertension are healthier and more in control of their health than they were in the past."

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>
> *—M. Michelle Hood, FACHE*

Continuing to Learn, Preparing for Success

Over the past four years, EMHS has worked to connect its physicians and senior staff with other national systems, especially those with top-flight reputations. For example, it has partnered with Geisinger Health System of Pennsylvania. "We usually set it up so we have concurrent meetings, with an administrative track and a practice track going at the same time," Hood said. "Geisinger recently surveyed six of our primary care sites, assessed the processes, and compared them to its own primary care practices. We plan to pool our patient population data and see what we can learn from each other." Beginning in 2013, Geisinger Health Options will become the TPA and provide data analytic and care management support services for the EMHS employee health plan.

What are the critical factors for success in these experiments in new care delivery models? The first is access to reliable information. Data infrastructure must be available that connects the various parts of the care delivery system. Patients may use an emergency department in one community, a primary care practice in another, and be hospitalized in a third, but the system must have a clear perspective about the care journey and be able to coordinate services across these multiple sites of care.

In addition, Hood said, human factors are equally important. "Our workforce is innovative, collaborative, entrepreneurial, enthusiastic, and patient centered. Those cultural factors you just can't buy. You either have that culture, or else you work on getting that culture."

At present, EMHS is dealing with two different payment models side by side. "That is a huge challenge for us," Hood noted. "One reason we're so interested in working with commercially insured patients, as well as with our state Medicaid program, is that we want to get to the tipping point where the majority of the patients we care for are in the population-based approach, rather than fee-for-service. We don't know exactly when we are going to get there, although 2014 is a tentative target. At the same time, we don't want providers worrying about whether the patient is a fee-for-service patient or not—we want to deliver the right care, regardless."

EMHS is preparing itself for a significantly different future. "As we move into a shared-risk environment, as we walk away from fee-for-service, there is going to be a major shift in how hospitals earn their dollars," said P. James Nicholson, CPA, the current chair of the system board. "In the future hospitals will earn their dollars through a healthy client base. Becoming a system with governance integration will allow us to focus on keeping our general population as fit and well as possible, rather than looking at specific bottom lines. In the past we made a decision to move forward, and now we find ourselves way ahead of the curve compared to hospitals that have been in a wait-and-see mode."

Conclusion

The healthcare provider industry is in a state of flux, moving from fee-for-service payments—driving volume up—to an entirely new, authentic care management approach of enhancing the wellness of identified patient populations—to reduce the costs of care and drive volume down.

THIS ENTIRELY NEW BUSINESS MODEL CREATES A DIFFICULT conundrum for provider organizations in determining short- and long-term strategy, as there will be a period of time in which providers will be dealing with both FFS contracts and value-based payment models. It is yet to be determined how long this transition will take, but providers can consider proactive options now to interact with payers and create payment strategies that will succeed.

Healthcare is still very much a local business and it will be critical to understand local market dynamics in order to select strategies that will bring success. Different strategies will be relevant depending upon the provider organization's aspirations and roadmap.

So it seems there is indeed a bridge from volume to value that likely requires two different organizations to implement both models successfully. The companies that are successful at population health management don't look like the traditional hospital system. Hospital systems can certainly take advantage of this trend by creating a separate organization that manages the value-based population contracts, while simultaneously preparing for the cost and volume changes to the current business. Population health management has the potential to drive traditional volumes down; however, the opportunity to operate at a lower cost structure can convert the value delivery to incremental volume. Healthcare boards and senior leaders have a long list of questions to ask themselves to help determine viable strategies. Here is a list to begin the discussion.

Key Questions for Board Members

1. What are our current financial and clinical results for our inpatient business, outpatient business, and physician enterprise?
   a. How do these results compare to local and national benchmarks?
   b. What is our competition in each area and how are we differentiated?
   c. Can we make money on each line individually if payment were to decline to at or below Medicare rates?
2. What is the current supply and demand for essential healthcare services in our market and how is this going to change over time?
   a. In a market where there is a shortage of hospital beds, it will be difficult for any outside organization to play a significant population health management role.
   b. Primary care physicians are the foundation to a program.
   c. Select specialists based on effectiveness and efficiency.
3. What current competencies do we have for population health management?
   a. Data infrastructure
   b. Management talent and staff with experience in population health management
   c. Patient-centric care management systems
   d. Business processes that have proven results of increased quality and reduced costs
4. What percent of our revenue and profit comes from risk- or performance-based contracts?
   a. What are we doing to manage this business?
   b. How do we expect that business to change in the future?
5. Who in our market is best positioned to be the population health manager?


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