Accountable Care and Population Health

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Learning Objectives

• Describe goals for accountable care and population health
• Explain the difference in moving from volume to value
• Identify challenges to accountable care and population health
• Accountable care and population health as part of health care reform
• Goals for accountable care and population health
• Required competencies and tools
• Challenges in succeeding
## Key Components

Over 10 Years, the Bill will Expand Coverage to 34 million–95% of all Americans–23 million will remain uncovered

<table>
<thead>
<tr>
<th>Health Insurance Marketplaces</th>
<th>Medicaid Expansion</th>
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</table>
| • State-based insurance exchanges  
• Open Enrollment October 2013, Plans start January 2014  
• Subsidies to moderate-income Americans to buy insurance coverage in Exchange (up to 400% FPL). | • Beginning in 2014, the Medicaid program will be expanded  
• Includes parents, children and childless adults up to 133% of FPL (approximately $14K for an individual and $29K for a family of 4). |

<table>
<thead>
<tr>
<th>Medicare</th>
<th>Insurers, Employer &amp; Individuals</th>
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</table>
| • Accountable Care program  
• Bundled Pricing pilot programs  
• Value Based Purchasing (readmissions, etc.)  
• Enhanced benefits (closing “donut hole”, preventive care, etc.)  
• Medicare Advantage | • Provide preventive care, young adult coverage,  
• No lifetime limits/pre-existing conditions  
• Individual mandate to obtain insurance  
• Employer responsibility to provide “affordable care”  
• Increased emphasis on wellness and health improvement |
**Goals for Accountable Care and Population Health**

**Reduce Cost**
- Lower, Different Utilization
- Lower Unit Cost, New Payment Methods

**Engage Consumers of Care**
- Benefit Plan Design
- Transparency and Purchasing Power
- Health Improvement Programs

**Improve Quality**
- New Models of Care
- Evidence Based Medicine

**Use Health Information Technology**
- Adoption
- Optimization
- Interoperability
Moving to the Second Curve

Where Will You Be In 5 Years?

First Curve: Paying for Volume

- Fee-for-Service Payment System
- Readmission Rate Penalties
- Managed Care Medicare/Medicaid

Second Curve: Paying for Value

- Accountable Care Organizations
- Bundled Payment Pilots
- Direct Contracts with Employers
- Option on the Health Marketplace

Second Curve: Paying for Value

- Population Health; Per Capita Payment System

Adapted from Ian Morrison
Rush’s Experience on the Curves

1970’s-1980’s
- 1978: HMO for employees
- 1981: Staff Model HMO for Commercial Market
- 1987: IPA Model HMO for Commercial Market

1990’s
- 1994: JV with Prudential
- 1994: Physician-Hospital Organization
- 1997: Management Services Organization

2000’s-Present
- 2001: JV Sold to Unicare
- 2003: Began Exit from Capitation
- 2012: $43m in P4P Payments
- 2012: Direct Contracting
<table>
<thead>
<tr>
<th>From</th>
<th>To</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fee for Service Payment</td>
<td>Risk and/or Incentives for Keeping Patients Healthy.  <strong>P4P (Pay for Performance), Shared Savings, Capitation</strong></td>
</tr>
<tr>
<td>Care Not Coordinated Between Providers</td>
<td>Providers Managing Continuum of Care. Right Care at the Right Place/Time. <strong>Care Coordination, Transitions of Care leveraging community resources</strong></td>
</tr>
<tr>
<td>No Shared Patient Information</td>
<td>Electronic Health Records enable information Sharing.  <strong>Health Information Exchange</strong></td>
</tr>
<tr>
<td>Doctors Wait for Sick People to Show Up</td>
<td>Predictive modeling, Proactive Monitoring and Outreach.  <strong>Telemedicine, Patient Centered Medical Home, Home visits</strong></td>
</tr>
<tr>
<td>Patients Wait for Providers to Tell Them What to Do</td>
<td>Patients Actively Engaged in Improving and Managing their Health.  <strong>Personal Health Records, Home Monitoring Devices, Patient Engagement</strong></td>
</tr>
</tbody>
</table>
Required Competencies and Tools

Cost Control
- Financial Management
- Care Coordination
- Case Management

Quality Improvement
- New Models of Care
- Defined Quality Standards
- In CMS Program, no Shared Savings if Quality Measures Unmet

Information Technology
- Electronic Medical Records
- Health Information Exchange
- Business and Clinical Intelligence

Contracting
- Core Providers
- Contracted Clinical Services
- Contracted Support Services

Patient Activation
- Identification
- Engagement
- Self-Management
Provider Scale Increases Chances of Success

Continuum of payment bundling:
- Risk-adjusted global fee with risk mitigation (e.g., reinsurance)
- Global ambulatory care fee and bundled acute case rates
- Global primary care fees
- Blended FFS and medical home fees

Quality bonuses for:
- Patient outcomes: large % of shared savings, some shared risks
- Care coordination and intermediate outcome measures: moderate % of shared savings
- Preventive care and management of chronic conditions: small % of shared savings

Less feasible

More feasible

Source: The Commonwealth Fund
Challenges to Accountable Care & Population Health

**Patient Attribution**
- Based on plurality of primary care expenses
- Patients frequently use multiple health systems
- Your patients may not be your patients

**Information Technology**
- CMS/Payer data is claim based; significantly retrospective
- Low adoption of EMRs
- Lack of interoperability

**Patient Engagement**
- Patients unaware they are “in” an ACO
- Patients can opt-out or ignore new services
- Benefit plan design/provider networks

**Sustainability**
- Once low hanging fruit is picked, what next?
## Health Systems Participating or Planning to Participate in “Accountable Care” Models Admit Many Challenges

<table>
<thead>
<tr>
<th>Obstacle</th>
<th>Participating</th>
<th>Planning to Participate</th>
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<tbody>
<tr>
<td>Reducing clinical variation.</td>
<td>3.62</td>
<td>3.12</td>
</tr>
<tr>
<td>Reducing costs.</td>
<td>3.62</td>
<td>2.99</td>
</tr>
<tr>
<td>Developing and maintaining common culture.</td>
<td>3.55</td>
<td>3.14</td>
</tr>
<tr>
<td>Aligning incentives to encourage productivity but minimizing wasteful utilization.</td>
<td>3.47</td>
<td>3.05</td>
</tr>
<tr>
<td>Motivating physicians to participate.</td>
<td>3.37</td>
<td>2.65</td>
</tr>
<tr>
<td>Developing clinical and management information systems.</td>
<td>3.30</td>
<td>3.63</td>
</tr>
<tr>
<td>Resolving issues between primary care and specialists.</td>
<td>3.21</td>
<td>3.32</td>
</tr>
<tr>
<td>Access to capital.</td>
<td>2.96</td>
<td>3.62</td>
</tr>
<tr>
<td>Increasing the size of the covered population.</td>
<td>2.89</td>
<td>3.67</td>
</tr>
<tr>
<td>Developing physician leadership.</td>
<td>2.37</td>
<td>3.5</td>
</tr>
<tr>
<td>Developing a governance structure.</td>
<td>2.13</td>
<td>3.33</td>
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</table>

**NOTE:** Each obstacle was rated on a scale of 1 to 5 (1 = No Challenge and 5 = Extreme Challenge).

Revisiting the “80/20” Rule

50% of the population spends little or nothing

5% of the population

20% of the population

81% of total costs come from 20% of population

51% of total costs come from 5% of population

26% of total costs come from 1% of population

“Population Management” connotes everyone...claims data shows opportunities concentrated in small subset of beneficiaries

Source: IMS Institute for Healthcare Informatics, February 2012: "Healthcare Spending Among Privately Insured Individuals Under Age 65"
50% Spread in Lung Cancer Costs Between High and Low Cost Markets

Average cost per lung cancer patient over 24 months studied (Surgery with Radiation)

Highest Cost Markets: $157,360
Mean, All Markets: $132,543
Lowest Cost Markets: $102,528

Note: Unit prices standardized to eliminate regional variation in commercial payments
Source: Milliman analysis of commercial insurer claims data 2009-2010
Percent of Stage IV Lung Cancer Patients Undergoing Surgery

Source: American College of Surgeons National Cancer Data Base, 2009
Total Episode of Care Cost for Lung Cancer, Deceased Patient Cohort

- No hospice, death in hospital: $35,742
- Hospice, death in hospital/facility: $38,484
- Hospice, death at home: $41,079
- No hospice, death at home: $37,164

Source: Milliman Analysis of Medicare Claims 2009-2010
Employer Spinal Fusion Cases

Surgery Admission Only

Allowed per Case based on $10K Increments
“Centers of Excellence” Translates to Less Variability

Rush Spinal Fusion Cases

Surgery Admission Only
Payer/Provider Partnerships

- Jointly develop strategy, analytics infrastructure, and quality agenda
- Actuarial expertise, claims, core administration held by payer
- Network, payment terms, incentive plans held by provider
- “Volume for Value”

Shared Savings/Traditional Capitation Programs

- Providers bear almost all cost to implement/manage
- Benefits disproportionately accrue to payer
- Cost to raise the bar after initial success likely exceeds potential return
- Less is not more

Provider Programs

- Direct contracts for bundled payments
- Carve-out disease management and care coordination
- Custom network based on “ACO” framework
- Can be effective solutions for self-insured employers
Thank You!

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