Perspectives, Priorities, and Leadership
John Bertko, FSA
Senior Actuarial Advisor, CCIIO

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Key Concepts

- Managing a population
- Creating “systems of care”
- Measurement using data for all services provided to beneficiaries
- ACO infrastructure
- Understanding budget risk
- Recipes for success

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Managing a Population

• Focus for an ACO changes from delivering services for patients to managing quality and cost of a population
  – Who is the population?
    • Medicare – attribution using PCP services
    • Private insurance –
      – Attribution, or
      – Enrollment in a “product”

• Longer term investments may now be practical
  – Controlling diabetes, hypertension, smoking, and body weight
  – Investing in extended hours and open scheduling practices
  – Understanding costs and quality of whole episodes of care (e.g., a hip replacement)

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<table>
<thead>
<tr>
<th>Service Category</th>
<th>Admissions per 1,000</th>
<th>Length of Stay</th>
<th>Total Utilization per 1,000</th>
<th>Allowed Average Charge</th>
<th>PMPM Claim Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient Facility</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical</td>
<td>16.4 Admits</td>
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<td>47.8 Days</td>
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<td>Surgical</td>
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<td>Skilled Nursing</td>
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<td>21.6 Days</td>
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<tr>
<td>Total Inpatient</td>
<td>48.1 Admits</td>
<td>3.35</td>
<td>161.0 Days</td>
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<td>$62.64</td>
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<tr>
<td>Emergency Room</td>
<td>104 Cases</td>
<td></td>
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<td>$1,342.87</td>
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<td>Surgery</td>
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<td>$3,258.70</td>
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</tr>
<tr>
<td>General</td>
<td>163 Cases</td>
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<td>$306.74</td>
<td>$4.17</td>
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<tr>
<td>CT/MRI/PET</td>
<td>27 Cases</td>
<td></td>
<td></td>
<td>$1,313.96</td>
<td>$2.96</td>
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<tr>
<td>Outpatient Total</td>
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<td>$45.85</td>
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<td><strong>Professional</strong></td>
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<tr>
<td>Office/Home Visits</td>
<td>2,669 Visits</td>
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<td></td>
<td>$63.50</td>
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<td>$151.78</td>
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<td>Inpatient Surgery</td>
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<td>General</td>
<td>727 Proced</td>
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<td>$92.81</td>
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<td>CT/MRI/PET</td>
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</tr>
<tr>
<td>Professional Total</td>
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<td>$53.48</td>
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<tr>
<td><strong>Total Medical Cost</strong></td>
<td></td>
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<td>$250.64</td>
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</table>


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## Managing a Population

<table>
<thead>
<tr>
<th>Service Category</th>
<th>% of beneficiaries with claims</th>
<th>Services per user</th>
<th>Services per 1,000 beneficiaries</th>
<th>Expenditure per service</th>
<th>PMPM Claim Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient Facility</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical</td>
<td>13%</td>
<td>1.6 Admits</td>
<td>215 Admits</td>
<td>$6,302.65</td>
<td>$123.03</td>
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<tr>
<td>Surgical</td>
<td>7%</td>
<td>1.2 Admits</td>
<td>83 Admits</td>
<td>$16,844.78</td>
<td>$127.40</td>
</tr>
<tr>
<td>Skilled Nursing</td>
<td>5%</td>
<td>37.7 Days</td>
<td>1,802 Days</td>
<td>$350.47</td>
<td>$57.41</td>
</tr>
<tr>
<td><strong>Total Inpatient</strong></td>
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<td></td>
<td></td>
<td></td>
<td>$341.35</td>
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<tr>
<td><strong>Outpatient Facility</strong></td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>Emergency Room</td>
<td>20%</td>
<td>2.8 Visits</td>
<td>553 Visits</td>
<td>$104.50</td>
<td>$5.26</td>
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<tr>
<td>Procedures</td>
<td>13%</td>
<td>17.0 Proced</td>
<td>2,148 Proced</td>
<td>$92.02</td>
<td>$17.97</td>
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<tr>
<td>Imaging</td>
<td>38%</td>
<td>3.7 Proced</td>
<td>1,400 Proced</td>
<td>$105.98</td>
<td>$13.49</td>
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<tr>
<td><strong>Outpatient Total</strong></td>
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<td></td>
<td></td>
<td>$95.35</td>
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<tr>
<td><strong>Professional</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Visits</td>
<td>70%</td>
<td>7.7 Visits</td>
<td>5,373 Visits</td>
<td>$52.38</td>
<td>$25.48</td>
</tr>
<tr>
<td>Inpatient Visits</td>
<td>18%</td>
<td>15.8 Visits</td>
<td>2,912 Visits</td>
<td>$62.84</td>
<td>$16.64</td>
</tr>
<tr>
<td>Emergency Room Visits</td>
<td>24%</td>
<td>2.0 Visits</td>
<td>470 Visits</td>
<td>$92.87</td>
<td>$3.97</td>
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<tr>
<td>Radiology</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Standard imaging</td>
<td>54%</td>
<td>10.8 Proced</td>
<td>5,823 Proced</td>
<td>$15.62</td>
<td>$8.27</td>
</tr>
<tr>
<td>CT/MRI/PET</td>
<td>27%</td>
<td>2.9 Proced</td>
<td>799 Proced</td>
<td>$107.61</td>
<td>$7.81</td>
</tr>
<tr>
<td><strong>Professional Total</strong></td>
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<td></td>
<td></td>
<td></td>
<td>$187.24</td>
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<tr>
<td><strong>Home health</strong></td>
<td>8%</td>
<td>38.4 Visits</td>
<td>3,170 Visits</td>
<td>$141.50</td>
<td>$40.78</td>
</tr>
<tr>
<td><strong>DME</strong></td>
<td>26%</td>
<td></td>
<td></td>
<td></td>
<td>$24.12</td>
</tr>
<tr>
<td><strong>Total Medical Cost</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$709.87</td>
</tr>
</tbody>
</table>

Source: Centers for Medicare & Medicaid Services, Unpublished Data, 2008

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Creating New “Systems of Care”

- ACO provider networks
  - PCPs as key ACO participating providers
  - Specialists – either:
    - Part of the ACO network as care coordinators (e.g., cardiologists)
    - Outside in the community, receiving referrals
  - Hospital:
    - Sometimes as an ACO participating provider
    - Sometimes as a community provider
    - Tertiary care hospitals for certain procedures
  - Other providers – labs, imaging centers, post-acute facilities, etc.

- “Leakage” to non-ACO providers:
  - How much?
  - For which services?

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“Systems of Care”

• Systems come in many forms, suited to local conditions:
  – PHOs
  – Physician groups
  – Hospitals with employed physician groups, usually also with some community physicians
  – Integrated Delivery Systems (IDSs)

• Key concept:
  – All have a formal organization structure as an ACO
  – All have contractual arrangements for services and payments

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Measurement Using Data

• Multiple data streams
  – Local EMR data
    • Near-real-time data feeds at the clinician’s site
    • Possible additional data from local health information exchanges (HIEs)
  – Additional clinical data
    • Lab data feeds
    • Rx data may be possible
  – Payor data feeds
    • Periodic feeds for all claims paid
    • Will include non-ACO claims/services, but with a lag

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Measurement Using Data

• Examples of data analyses tools
  – Quality reporting
    • Quality “scoreboards” by physician (e.g., for CAD or diabetes measures)
    • Registries
  – Cost metrics
    • Actual to target, by specialty service or service type
    • “Drill down” reports by each specialist
    • Referral costs, by episode
    • High-cost cases

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ACO Infrastructure

• Some of the services needed:
  – Claims adjudication (if needed)
  – EHR
  – Utilization management
  – 24/7 nurse hotlines
  – Budget monitoring
  – Measurement reporting
  – Network contracting (depending on the size of the ACO)
  – Patient education and handbooks, etc.
  – Credentialing of ACO providers
  – Quality improvement programs

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ACO Infrastructure

• Where to obtain services:
  – “Make vs. Rent” dilemma
    • More control when an ACO invests funds into some or all of these components
    • Lower (or no) upfront investment to “rent” ACO services from available organizations
      – Some Management Service Organizations (MSOs) have a long history of serving capitated medical groups
      – Some insurers may “rent” their surplus capacity
      – Other single-service organizations (e.g., data reporting or utilization management)

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ACO Infrastructure – Sample Timeline

- Decision to form an ACO
- Inventory internal capability
- Discuss needed services
- RFP prepared
- RFP released
- MSO vendors proposals received and reviewed
- Final MSO terms negotiated
- Implementation
- “Go live” date
  - 1/1/XX
  - 2/1
  - 3/1–4/1
  - 4/1–5/1
  - 6/1
  - 8/1–9/1
  - 9/15–30
  - 10/1–12/15
  - 1/1/XX+1

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Understanding Budget Risk

• “Budget risk” is holding ACO providers responsible for the cost and quality of care provided to a defined population of patients
• Two main types being discussed:
  – “Bonus only,” where good performance on both quality and cost leads to gain sharing
    • Generally a threshold must be exceeded before payments are made
  – “Upside/downside” risk where the ACO is rewarded for good performance but also may owe a repayment if the budget is exceeded

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Budget Risk

• Based on:
  – Attributed patients
  – Historical patterns of care, as seen in claims data
  – A trend factor to project into the “budget year”
  – Any necessary adjustment for changes in population risk
  – Adjustments for new entrants, deaths, and those leaving the ACO (e.g., people who move out of the area)

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Patient Responsibility

- Patients of an ACO have responsibilities:
  - See their PCP first! (But not as a gatekeeper)
  - Take actions to maintain their own health
    - Ask questions
    - Listen to and act on directions of the care coordination team
    - Recognize their own role in staying healthy
    - Improve their health literacy

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Recipe for Success

- Formal structure of ACO providers
- Understanding the history of the ACO population
- Focusing on specific clinical intervention tactics
- Measuring quality and cost on a frequent basis
- Teamwork – physicians, RN and other clinicians, hospital staff, payor reps
- Great leadership and vision of a new system!
Perspectives, Priorities, and Leadership

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