HCPA → ACA & on to ACOs

Philip Gaziano, MD
President & CEO of ACA
November 30, 2010
1970s->2010s Attempts at Medical Cost Containment

1. Reducing Fees (All)
2. Partial Capitation
4. Global Cap. + Local MD Managers* (With Delegation + Risk Sharing)*

Medicare Advantage is most common*
Proposed ACO Structures: (Massachusetts & Federal)

PCPs
PCPs + Specialist
PCPs + Specialist + Hospitals
Any of the Above + Payers
(all must have Infrastructure)
Why Should ACO’s be Physician Driven?:

In Hampden, Hampshire, & Franklyn Counties the pen above (and others like it) can order either:

$4,000,000,000 of health care expenses, or

$3,500,000,000 and give higher quality care.
HCPA / ACA’s Move to ACOs
(Past, Present, Future)
1996…The Dawn of MA Global Capitation In Hampden County

Noble Tufts Pods:
1. Noble Hosp. PHO
2. Pioneer

Holyoke Tufts Pod:
3. Holyoke Hosp. PHO

BMC/Mercy BCBS Pod:
4. River Bend
   (Medical West)

Mercy Tufts Pods:
5. PQC (MIMS)
6. PVP (MIMS)
7. HCPA

Which Pod was the first to lose Money?

Then HCPA got Infrastructure
2010… MA Global Capitation
In Hampden County

Noble Tufts Pods:
1. Noble Hosp. PHO
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Mercy Tufts Pods:
5. PQC (MIMS)
6. PVP (MIMS)
7. HCPA

Which Pod is Left?
…Because of our Infrastructure
HCPA / ACA Managed-Care
(Integrated) Clinical Infrastructure

1998 We Started Dedicated Hospital Day Rounding.
1998 We Started SNF/Sub-Acute Rounding.
1999 1st Case Manager Hired
2001 Became delegated for Case Management (follow NCQA)
2002 We Started Disease Management
2002 Included affiliated physicians
2004 Delegated for Disease Management (follow NCQA)
2005 We Developed a Paper Coding and Info. Sharing Tool
2008 Converted to a Web-Based Coding & Info. Sharing Tool
2009 We added a 2nd Medicare Plan… and the BCBS AQC
2010 New data tools, integration, and PIC’s into the offices
(We now manage $130 million/yr. of ACO type healthcare expenditures for >19,000 members)
## Managed-Care Priorities by Product

<table>
<thead>
<tr>
<th>Managed Medicare</th>
<th>Managed Commercial</th>
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</thead>
<tbody>
<tr>
<td><strong>Contracting</strong></td>
<td><strong>Contracting</strong></td>
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<tr>
<td>Network Maintenance</td>
<td>Network Maintenance</td>
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<tr>
<td><strong>Data Analysis / Registries</strong></td>
<td><strong>Data Analysis / Registries</strong></td>
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<tr>
<td>Medical Direction</td>
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<tr>
<td>Member Access to PCP</td>
<td>Member Access to PCP</td>
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<tr>
<td>Case Management</td>
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<td><strong>Disease Management</strong></td>
<td><strong>Disease Management</strong></td>
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<tr>
<td>Pharmacy Management</td>
<td>Pharmacy Management</td>
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<tr>
<td><strong>Dedicated Hosp. Rounding</strong></td>
<td>Dedicated Hospital Rounding</td>
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<tr>
<td><strong>Dedicated SNF Rounding</strong></td>
<td>Dedicated SNF Rounding</td>
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<tr>
<td><strong>Correct Coding</strong></td>
<td><strong>Correct Coding</strong></td>
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</table>
Disease Management Outcomes:

% of Total Expenditure by the Top 3% Utilizers

49% → 42% = $5,000,000/year savings

Started Disease Management
## Disease Management Satisfaction:

<table>
<thead>
<tr>
<th>Category</th>
<th>Excellent</th>
<th>Very Good</th>
<th>Good</th>
<th>Fair or Poor</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Get advice from CM when needed</td>
<td>61%</td>
<td>33%</td>
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<tr>
<td>CM calls when needed</td>
<td>44%</td>
<td>22%</td>
<td>10%</td>
<td>10%</td>
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<tr>
<td>CM courteous and professional</td>
<td>83%</td>
<td>13%</td>
<td>10%</td>
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<tr>
<td>Teaching materials effective</td>
<td>25%</td>
<td>33%</td>
<td>10%</td>
<td>11%</td>
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<tr>
<td>Return calls in a timely manner</td>
<td>61%</td>
<td>19%</td>
<td>10%</td>
<td>16%</td>
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<tr>
<td>Satisfaction w/ home care nurse</td>
<td>50%</td>
<td>22%</td>
<td>10%</td>
<td>22%</td>
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<tr>
<td>Hospitalized fewer times this year</td>
<td>44%</td>
<td>25%</td>
<td>10%</td>
<td>25%</td>
<td></td>
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<tr>
<td>CM knows your conditions</td>
<td>63%</td>
<td>22%</td>
<td>10%</td>
<td>10%</td>
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<tr>
<td>Overall satisfied w/ DM program</td>
<td>66%</td>
<td>20%</td>
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</table>
CareScreen

Our Data Sharing Service:
Web based on a secure server.
Used by offices with paper charts or EHRs.
Data given at the time of the visit.
Improves Chronic Disease Care & Coding.
Improves Pharmacy, and Quality.
Data Warehouse

Data drives Efficiency and Quality:

PCP’s need the most Data:
(P4P, Quality, Efficiency, Transparency…)

Multiple Data Feeds are Necessary:
(Claims, Hospital, Lab, PHO, IPA, EMR…)

Not Cheap, But Vital for Managing Risk
(Tools are here now and ready now)
Our Total Medical Care (MA) Cost Savings:

$15,000,000 /year

20% of our Total budget

Due to an Integrated Approach***
Our 1st Year AQC Outcomes:

- 7.9%
- 5.5%
- <3%

2009 Actual

& Quality and Satisfaction Greatly Improved
A Deloitte Report-Card:

There is a strong (but not exact) correlation between best practices and financial performance.

<table>
<thead>
<tr>
<th></th>
<th>HCPA</th>
<th>Group A</th>
<th>Group B</th>
<th>Group C</th>
<th>Group D</th>
<th>Group E</th>
<th>Group F</th>
<th>Group G</th>
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<td>Incentives</td>
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<td>Leadership</td>
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<td>Care Management</td>
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<td>In Patient</td>
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</tbody>
</table>

PMPM performance against benchmark

$$$ (Leading) $$$ (Advanced) $$$ (Established) $$$ (Emerging) $$$ (Emerging)

* Based upon 2008 Data.
** Relative to Deloitte Northeast Lightly Managed external benchmark.

KEY: ◼ Leading ◼ Advanced ◼ Established ◼ Emerging

TUFTS Medicare Preferred

ACCOUNTABLE CARE ASSOCIATES
Our ACA (MSO) Structure:

**Clinical Managed Care**
- Medical Leadership
- Hospital Day Rounding
- SNF/Sub-Acute Rounding
- Case Management
- Disease Management
- Coding and Info. Sharing
- Network Management
- Clinical Data Management
- Quality Support & Reporting
- P4P Support & Reporting
- Incentives and Alignment
- Culture Change***

**Administration Managed Care**
- Contracting
- Reinsurance
- Facility Tracking
- Network Development
- Network Maintenance
- Data Management
- Outcomes Reporting
- Compliance
- Marketing Support
- P4P Support (Quality)
- Strategic Planning

* *** indicates additional details or notes.
The ACA Networks:

130 PCPs

>600 Specialists

50% in groups of 3 or less

50% PCPs Still on Paper Charts

200,000 < 65 Members (6% in our AQC)

55,000 Medicare Members (11% in our MAs)

$1.9 Billion Health Expenditures/ Year
Provider Perspectives:

Access, Quality, and Efficiency:
1. Work Flow is important
2. Satisfaction comes from Quality
3. All have Need for more Data
4. Contract Incentives Must be Understood
5. Infrastructure = Vital
6. Integrated with Providers is Best
ACOs and Quality:

1. A new set of Quality Measures ( Mostly for PCPs)
2. AQC Quality = 10% of budget ($2.4 Million)
3. CMS Quality = 10% of budget by 2014
4. Better Quality Improves Satisfaction & Savings
5. Different then the 80s ( More Quality)
6. Different then the 80s ( More Delegation)

• (Infrastructure Helps All)
Thoughts About ACOs:

- Different models for Different Networks
- Hospital Based vs. IPA (Doc) led
- (we need both types, + some hybrids)
- Infrastructure helps all models***
- (Integrated Infrastructure is best***)
- Quality First = Better Outcomes + Savings
- Transparency in all Directions
- Shared Savings + Quality = No Losers
ACOs: Providers + Knowledge, And Infrastructure
The Future is Ours