Summary: Right care or health enhancement interventions; right place; right time; right cost. This is THE goal.

In March 2010, President Obama signed into law the Affordable Care Act.
**Care Management Goals**

- Improved clinical outcomes, better health
- Accountability to outcomes
- Data, metrics, and outcome management
- Reduced cost
- Reduced utilization through improved health. Care Management reduces duplication, errors, and improves efficiency.
- Improved patient experience
  - Healthy citizens who are actively engaged in their own health care and health enhancement. A positive experience within a system of care centered on them.

**Care Management**

- The top 5% of a population spend about 75% of the dollars
- Manage these members first
- Find them through utilization, claims, and clinical data
- Design care models based on disease states and health needs, reduce variation in processes of care
- Increased value

**Managing Risk**

- The next 45% of the population spend about 25% of the dollars
- Manage these members next
- Use predictive modeling from shared data sources (clinical and claims data) to finding ‘rising risk’ members

**Managing Risk and Care Management**

- The last 50% of the population spend about 0% of the dollars
- Manage these members through community and clinical education and wellness opportunities.
- Build longitudinal charts centered on the individual
- Watch for predictive rising risk
Fee For Service, (FFS)

No meter, but this is how providers are paid in a volume based system of payment. In a value based system pay is for outcomes and health.

Volume to Value
An Example

- This is Mr. Smith
- He is diabetic
- He has not been engaged with controlling his disease
- Mr. Smith needs medical help

- Mr. Smith might require admittance to the hospital
- Mr. Smith will be treated, given medication and discharge plans. Despite education about his disease and how to self-care, his engagement is likely to be as before

- Mr. Smith is going back home, treated and improved, but still at risk for further preventable admissions.

- What can be done to keep Mr. Smith healthier?
  - To improve his clinical outcomes?
  - To reduce the personal impact and dollar cost of his disease?
Mr. Smith is back at home

He is struggling to control his disease

He is a member of a local ACO which assigns a Care Manager to visit Mr. Smith

Mr. Smith’s Care Manager helps him understand and treat the causes of his disease

His CM explains his medications to him and makes sure they are used correctly

The CM helps Mr. Smith connect more regularly with his PCP and others who provide his care across the community

Most importantly, the care manager helps him do all of this and supports his efforts at engagement

Mr. Smith stays out of the hospital, he feels better and he returns to a healthier state

Mr. Smith’s avoidable readmission would have cost $15,000

Instead $3000.00 was spent over a year on Care Management, preventative education, administrative overhead and appropriate treatment for Mr. Smith all of which avoided that hospitalization

This is better care, better health and at a better cost. This is Value

Does everyone benefit?

Provider Dilemma

Movement from Volume to Value:

- In a Fee For Service payment system, decreased volume of services means decreased revenue for providers – not sustainable
- When better care and better health decrease volume of needed services, this is good for populations
- The resulting decreased costs are good for the ultimate payers
- How to bring this together in a sustainable system is the key
Gains in Efficiency Result in Reduced Volumes

Gains are Found in Clinical Programs

Gains are Limited Over Time

Even though these gains in efficiency are time limited, they will continue to drive down volumes. This will result in lower revenue.

The Law of Diminishing Returns…
Where is the Revenue?

Joining in Up-Side Risk

Initial efficiency savings come back to the organization, but taper off as final benchmarks are reached.

Partnering for Shared Savings / Risk

Shared Savings allows for the organization to set consistent ongoing benchmark savings through Pop Health activities for specific populations.

Full Capitation, Full Risk

Full risk assures the organization can capture all known savings and continue to find savings through additional clinical efficiencies.
Infrastructure Required

- Fundamental concept – what formerly were provider operational consideration and payer issues are now clinical issues
- Clinical data sharing
- Aggregation of data for retrospective analysis and predictive analytics
- Registry data for care management system:
  - Chronic disease management
  - Focused health enhancement
  - Reduce variation in care delivery
  - To reinforce goals of PHM

New Alliances Necessary
Accountable Care Organization

How it Works

• Within the ACO model, patients will be empowered with access to competitive networks of providers offering quality healthcare at relatively lower costs.

• As consumers, patients will need to be aware of the changes in the healthcare delivery system to better take advantage of competing services.

• Physician networks and hospitals will need to increase their collaboration to achieve high quality care and to ensure profitability under the new payment models.

• Payers will have to ensure buy-in from the provider community to sustain the shared savings model, much of which is accomplished through new partnership models and data sharing initiatives.

• Health IT vendors will have to prove their products’ value to ACO decision makers to assure access to the most appropriate therapies, technologies and information will be preserved at all times.

What elements make a successful ACO?
Sustaining Innovation in Clinical Programs

- A successful ACO will strive to continually find innovative ways to improve quality and decrease costs.

For example, the top 1% by cost in any given year account for most of the spending. But only the Top 1% consistently remain high cost; the other 4% move in and out every year, as shown.

The next “Top 5%” are the fluid set of specific patients whose costs are about to jump the most. Identifying, engaging and sustaining care for these members requires continual innovation in clinical programs.

New Payment Models

- ACO providers will expect compensation that reflects their contribution to professional services rendered, quality of care, and cost savings.

- Typical physician compensation models—emphasizing quantity of service as opposed to quality of service or outcomes—will be less useful in the ACO environment.

- Contracts will need to migrate to payments based on different performance measures and not solely on productivity measures.

Technical Infrastructure

- In order to reach the level of integration required for coordination of patient care, an ACO must make technology enhancements to effectively quantify results and provide quality reporting measurements.

Shifting Payment Models

- Fee for Service to Accountable Care and Risk

<table>
<thead>
<tr>
<th>High-performing provider network</th>
<th>High-value episodes</th>
<th>Population management</th>
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</thead>
<tbody>
<tr>
<td>- Best outcomes in quality, safety</td>
<td>- Care (DRG) episode targeting</td>
<td>- Population analytics</td>
</tr>
<tr>
<td>- Waste elimination</td>
<td>- Care models and gainsharing</td>
<td>- Care management</td>
</tr>
<tr>
<td>- Most efficient supply chain</td>
<td>- Data analytics</td>
<td>- Financial modeling and management</td>
</tr>
<tr>
<td>- Satisfied patients</td>
<td>- Cost management</td>
<td>- Legal</td>
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<td></td>
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<td>- Physician integration</td>
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Strategic Vision

- A successful ACO has a clear strategy to create value and be sustainable in the long term
- A deep understanding of the sources of value (e.g., clinical quality and total cost of care)
- Fine tuned targeted care management approaches to capture value
- Operational capabilities necessary to manage populations
- A clear operational model that focuses on new payment models without becoming muddled with older fee for service concerns
- Controlled investment costs that allow for structured financial arrangements between the ACO, provider and payers

Partnering with Payers

- Payers are consolidating resources and provider expertise by contracting with ACOs,
- The ACA has implemented mandates that expand benefits, implement minimum medical loss ratio requirements (MLR), prohibit preexisting condition exclusions, and increase pressure to freeze premiums
- By contracting with ACOs, payers are seeking to shift these added pressures to the ACO
- Self-funded employers and ACOs – an emerging relationship

An Awkward Transition

What happens when the gains in efficiency outpace annual growth or utilization?

- Good ACO structure and care management will result in fewer IP admits
- As care management drives to the ‘next five percent’ and beyond, efficiency gains and cost savings will flatten out
- This could leave a clear gap in utilization and fee based services, however, a strong ACO will overcome this in several ways
  - ACO gains in market share will create more demand for fee based services addressing excess capacity
  - Payor and employer partnerships to assure revenue based on capitated models. Fill the gap with shared savings and eventually full risk.
Summary

- The shift from volume to value is nuanced and the driver of massive change in healthcare
- The rate of change is daunting
- Population Health is the strategy to address this new environment:
  - Better care
  - Better Health
  - Better cost
- New collaborations are essential to accomplish PHM
- Care management systems are the keystone function