RELIANCE CONSULTING GROUP

HOW TO PREPARE FOR ACCOUNTABLE CARE CONTRACTING: PRIORITIES AND NEGOTIATIONS

Presented by :

John P. Schmitt, Ph.D.

RCG Managing Director

2-25-13

LEARNING OBJECTIVES

I. **Assess the trust level of each ACO contracting payer**

II. **Identify criteria to use in aligning payer-provider goals and values**

III. **Establish contracting priorities and develop negotiation strategies**

"Physician group practices should consider and carefully analyze participation in an ACO, bundled-payment pilot, or other initiative to respond effectively to emerging changes."

-Miranda Franco, "Evaluating Medicare ACOs and Bundled Payment Initiatives" MGMA Connexion, January 2013

AGENDA

- **Introduction: ACO Contracting Issues**
- **Learning Objectives**
- **ACO Readiness Assessment**
- **"Call to Action"**
- **Q & A**

INTRODUCTION: ACO CONTRACTING ISSUES

WHAT IT TAKES TO ENTER INTO AN ACO CONTRACT…

INTRODUCTION: ACO CONTRACTING ISSUES

WHAT IT TAKES TO MANAGE AN ACO CONTRACT…

INTRODUCTION: ACO CONTRACTING ISSUES

- **ACO Growth**
- **ACO Payment Models**
- **ACO Attributes**
- **ACO Infrastructure**

INTRODUCTION: ACO CONTRACTING ISSUES

ACO GROWTH:

- 2.4 million Medicare patients receive care through ACOs recognized by CMS (Centers for Medicare & Medicaid Services)
- 15 million non-Medicare patients get services from practices with CMS ACO status
- 8 million to 14 million patients are in ACOs run by commercial insurers
- 328 ACOs are reported as of November, 2012 up from 164 counted in September 2011-a 100% increase over the last year
- CMS nearly doubled the size of the ACO shared savings program as of January 1, 2013 with 106 new ACO contracts

Source: "ACOs already surging, poised for even more growth" amednews.com, 12/10/12

ACO PAYMENT MODELS:

The American Academy of Actuaries broke down five popular ACO payment models in a recent report (listed from lowest to highest level of risk):

1. **"One-sided" shared savings**-providers share in a portion of the savings they achieve in a modified fee-for-service model. There is only upside risk-no financial loss sharing
2. **"Two-sided" shared savings**-providers take on downside and upside risk in a fee-for-service based payment model
3. **Bundled/Episode payments**-providers receive a single payment for all of one patient's services for one episode of care…They take on the financial risk if the cost of treating an episode of care exceeds the payment.

INTRODUCTION: ACO CONTRACTING ISSUES

4. **Partial capitation/global payments**-providers may be at risk for some or all of physicians services…but not for hospital or other non-physician services
5. **Global payments**-providers receive monthly or annual payments, regardless of the care services they performed in that time period…The only way for a provider to increase its financial benefit is to increase efficiency and reduce costs

Source: "5 Payment Models for ACO Providers", Heather Punke, Becker's Hospital Review, 12/28/12

INTRODUCTION: ACO CONTRACTING ISSUES

The Commonwealth Fund and the Institute of Medicine have identified 11 attributes of a payment system that would be superior to the current delivery system:

1. Care would be patient-centered
2. Care would be safe and effective
3. Care would be timely and accessible
4. Care would be efficient with little waste
5. Care would be coordinated among providers and across facilities
6. Continuity of care and care relationships would be facilitated
7. Collaboration among providers would deliver high quality, low cost care
8. Patient's clinical information would be efficiently exchanged
9. Caregivers would engage patients in ways that would maximize health
10. Accountability for each aspect and for total care would be clear
11. Continuous innovation, learning and improvement would occur

Source: Kent Bottles, MD, medpagetoday's KevinMD, Jan. 3, 2013

INTRODUCTION: ACO CONTRACTING ISSUES

ACO INFRASTRUCTURE FOR POPULATION HEALTH MANAGEMENT

PATIENT POPULATION	GOAL OF SERVICE	INTERNAL CARE TEAM	INFORMATIONAL RESOURCES	EXTERNAL CARE TEAM
Healthy Patients	Preventative Care	PCP Mid-Level provider RN LPN/MA PSR	Self Management Tool EMR IT Reports Quality Data Patient Feedback	N/A
Acute Patients	Episodic Care	PCP Mid-Level provider RN LPN/MA PSR Care Coordinator	E-Visit Feedback Medication Management EMR IT Reports Quality Data Patient Feedback	Specialists ER & Urgent Care Hospitalists Home Health Providers Social Workers Mental Health Providers Community Resources
Chronic Patients	Chronic Care	PCP Mid-Level provider RN LPN/MA PSR Care Coordinator	E-Visit Feedback Medication Management EMR IT Reports Quality Data Patient Feedback	Specialists ER & Urgent Care Hospitalists Home Health Providers Social Workers Mental Health Providers Community Resources Case Managers
End of Life Patients	Palliative Care	PCP Mid-Level provider RN LPN/MA Caregiver Care Coordinator	E-Visit Feedback Medication Management EMR IT Reports Quality Data Patient Feedback	Specialists Home Health Providers Social Workers Mental Health Providers Community Resources

LEARNING OBJECTIVES

I. **Assess the trust level of each ACO contracting payer**

II. **Identify criteria to use in aligning payer-provider goals and values**

III. **Establish contracting priorities and develop negotiation strategies**

LEARNING OBJECTIVE I

Assess the trust level of each ACO contracting payer…

VALUE-BASED CONTRACTING DIFFERENCES

ACO Contracting Features:
Traditional FFS vs. Value-Based

Feature	Traditional FFS	Value-Based Methods
Payment	Retrospective reimbursement	Prospective payment w/ rewards & penalties
Risk	None	Shared savings & gain-sharing
Quality of Care	Assumed- P4P incentives	Measured & reported w/ rewards & penalties
Provider Integration	Not required/optional	Hospital, physician, & ancillary providers
Competition	Non-exclusionary; supply & demand driven	Patient Channeling and provider exclusions
Data Reporting	None required/P4P	Cost & quality metrics, utilization; patient satisfaction

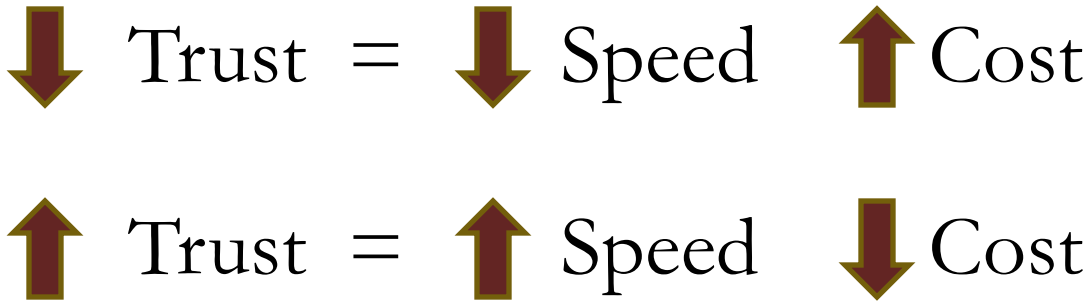
VALUE-BASED CONTRACTING CULTURE POSITIONING

Cultural Repositioning:
Traditional FFS vs. Value-Based

Issue	Traditional FFS	Value-Based Methods	Required Repositioning Competency
Trust Level Among payers, hospitals & other providers	**Low** Arms -distance contracts	**Med-High** Joint commitments, data sharing, payment distributions	**Building Trust** (next slide)
Goal Alignment Clinical, financial, & admin.	**Low** Goal conflicts: payers & hospitals	**Med-High** Protocol standards; common reports; savings distribution, shared risk	**Meaningful Collaboration**
Risk Disposition Upside & downside	**Risk Adverse** No risk	**Low-High** Shared savings; gain Sharing; capitation	**Medical Expense Management & Care Management**
Inter-Communication Payers, providers, & patients	**Minimum** Administrative (EOB); practice silos	**Med-High** Joint payer meetings; referral protocols, patient engagement	**Feedback & Assessment**
Technology Usage Real time capture, reporting & reconciliation	**Low** Paper; emails; etc.	**Med-High** Electronic; EMR, EHR, RHIO, dashboards	**Accepting & Embracing Technology**
Physician Behavior	**Physician-Centric** Change resistant, Independent, minimum compliance, reactive	**Other-Centric** Medical Home, payer collaboration, team leader oriented, engaged, pro-active	**Collaborative Attitude with Triple Aim Perspective**

ASSESSING TRUST LEVELS

- Payer Contracting is two-fold: **1) Tactical**- contract/fee adjustments; **2) Strategic**- payer relationship building
- Low trust causes friction and slows negotiations e.g. hidden agendas, win-lose thinking, defensive communication.
- High trust produces speed- e.g. transparent data, kept commitments, win-win-win solutions.



Source: The Speed of Trust, Stephen M.R. Covey

ASSESSING TRUST LEVELS

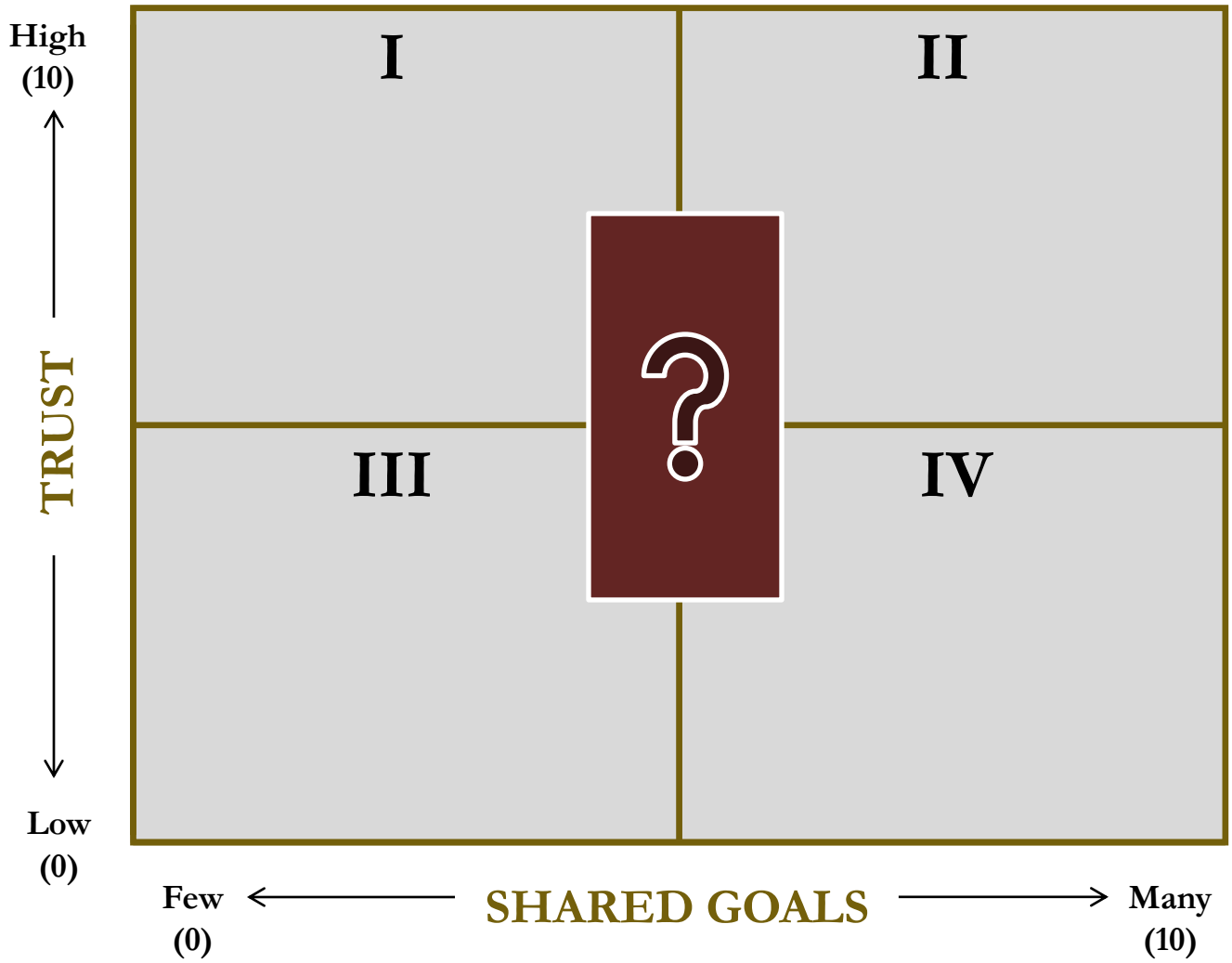
FOUR CORES OF TRUST BUILDING:

1. **INTEGRITY ("WALK THEIR TALK"):**
   - Three integrity builders: 1) actions reflect values; 2) commitments are made and kept; 3) open minded interactions and transparent information sharing
2. **INTENT (STAFF PROFESSIONALISM):**
   - Three intent measures: 1) professional /ethical behavior ; 2) honest & real communication; 3) win-win negotiation interests
3. **CAPABILITIES (STAFF COMPETENCE):**
   - Three capability characteristics: 1) works effectively with others; 2) subject knowledge; 3) focused sense of direction
4. **RESULTS (TRACK RECORD):**
   - Three results accelerators: 1) take responsibility; 2) expect success; 3) finish strong

Source: The Speed of Trust, Stephen M. R. Covey

ASSESSING TRUST LEVELS

ACCOUNTABLE CARE CONTRACTING MATRIX



ASSESSING TRUST LEVELS

TRUST ASSESSMENT CRITERIA

WHICH PAYERS HAVE INTEGRITY?

- Do they have a reputation of respect and trust?
- Do they have a culture of honesty?
- Do they listen to concerns and ideas?
- Do they admit to mistakes when they occur?
- Do they work through tough issues?
- Do they make and keep commitments?

ASSESSING TRUST LEVELS

TRUST ASSESSMENT CRITERIA

WHICH PAYERS HAVE GOOD INTENT?

- Do staff care about the quality of their work?
- Do payer systems reward competition (win-lose) or cooperation (win-win)?
- Is information shared freely or withheld?
- Do communications prove to be honest and sincere?

ASSESSING TRUST LEVELS

TRUST ASSESSMENT CRITERIA

WHICH PAYERS ARE CAPABLE?

- Do staff work effectively with others?
- Have they committed financial resources to achieve stated goals?
- Do they attract and retain knowledgeable and talented staff?
- Do they have a history of successful competition in the market?

ASSESSING TRUST LEVELS

TRUST ASSESSMENT CRITERIA

WHICH PAYERS GET RESULTS?

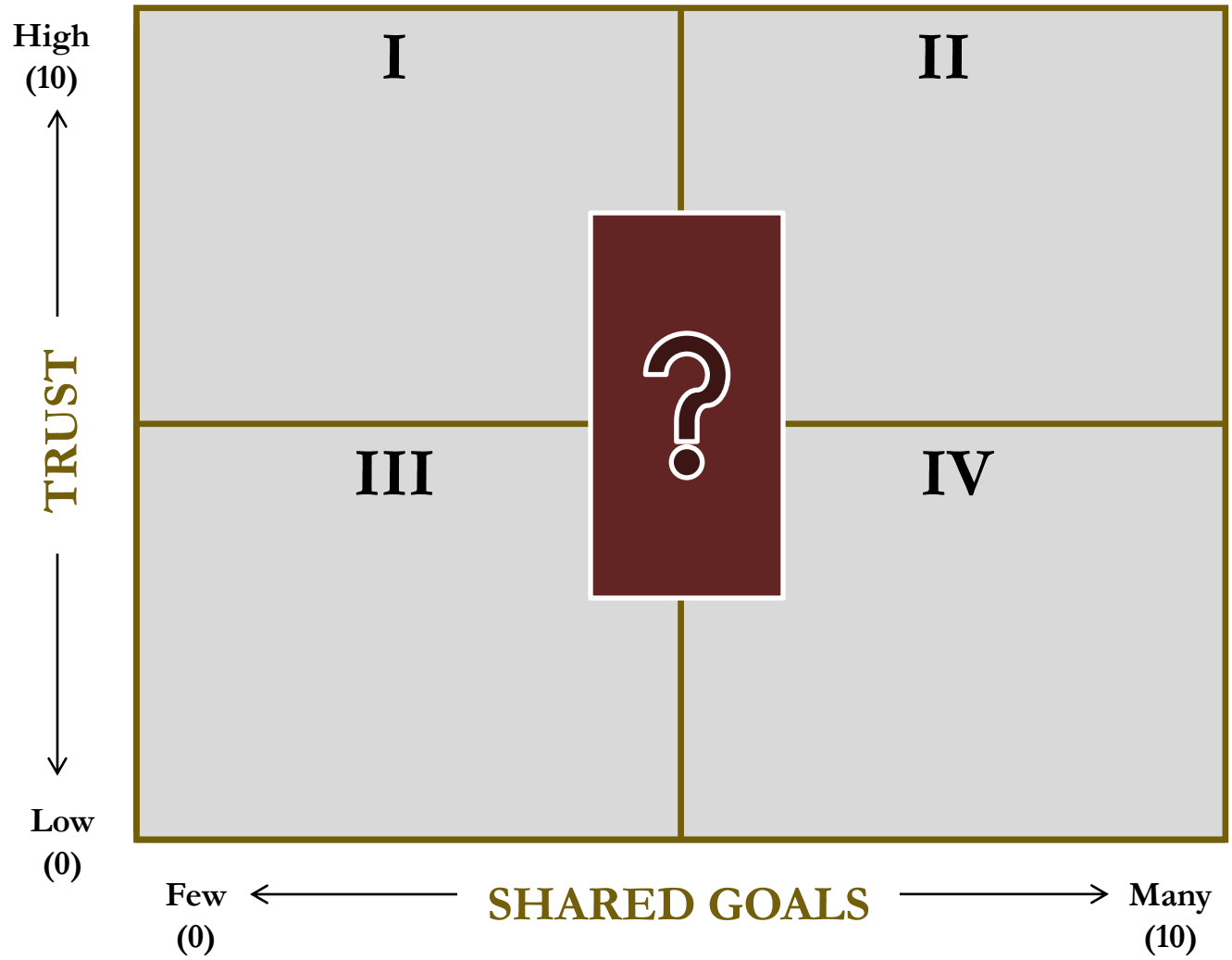
- Do they deliver what they promise?
- Does their track record promote confidence?
- Do they take responsibility for successful results?
- Would you recommend them to other practices?

LEARNING OBJECTIVE II

Identify criteria to use in aligning payer-provider goals and values…

ASSESSING TRUST LEVELS

ACCOUNTABLE CARE CONTRACTING MATRIX



GOAL ALIGNMENT

"It is time to stop shifting cost and align payers and providers around their common goals. Now is the time to bring together the two major constituents that affect cost, quality and outcomes. Payers and providers must collaborate in a meaningful way to truly manage the care and costs for our patients. And it all comes down to the need for alignment in three basic areas: clinical, economic and administrative."

Emand Rizk, The New Era of Healthcare, *Practical Strategies for Providers and Payers*, HCPro, 2009, pg. 11

CLINICAL GOAL ALIGNMENT

PAYER-PROVIDER AGREEMENT ABOUT:

- Definitions of clinical areas to be pursued as pilots e.g. orthopaedic procedures, cardiology episodes, …
- Best practice clinical guidelines that accommodate geographic variations, population differences, etc.
- Meaningful data extracted from payer claims and provider records to determine measures, targets, baselines & reconciliation processes
- Definitions of patient populations and attribution processes, e.g. age, condition, Medicare, Medicaid, Commercial enrollment

ECONOMIC GOAL ALIGNMENT

PAYER-PROVIDER AGREEMENT ABOUT:

- Reimbursement methods and amounts
- Financial incentives for cost, quality, and utilization e.g. gain-share terms
- Payment for support of care management programs e.g. care coordinators, case managers, quality tracking & reporting tools
- Population management program payments e.g. patient-centered medical home (PCMH) certification

ADMINISTRATIVE GOAL ALIGNMENT

PAYER-PROVIDER AGREEMENT ABOUT:

- Patient eligibility and benefit design e.g. payer information portals
- Availability of EHR portals for data sharing for patient's history, medications and tests
- Capabilities of electronic conveyance of patient data e.g. reporting and reconciliations
- Auto-adjudication, feedback and transparency to reduce claim rejections

LEARNING OBJECTIVE III

Establish contracting priorities and develop negotiation strategies…

CONSTRUCTING CONTRACTING MATRIX

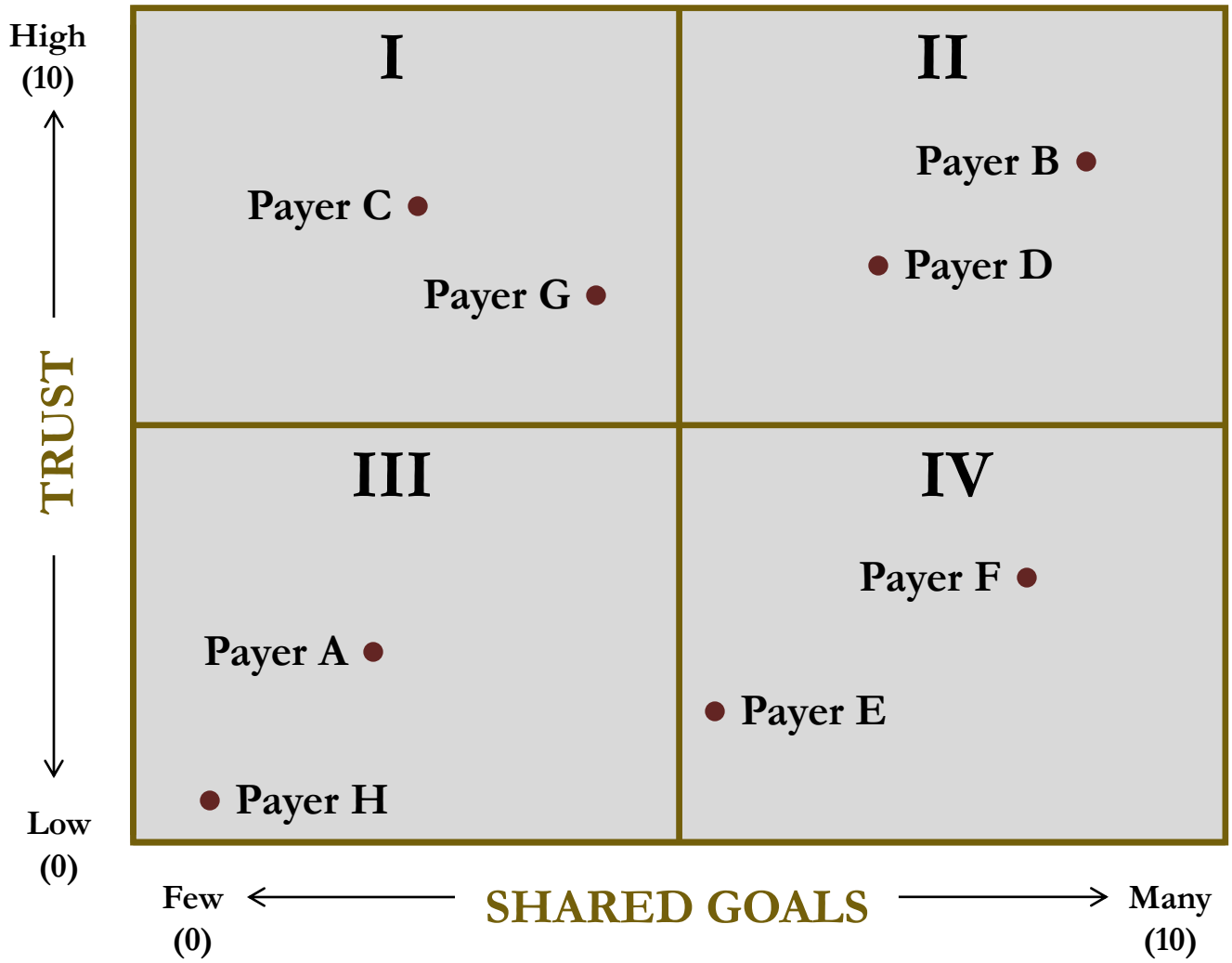
IDENTIFYING DESIRABLE BUSINESS PARTNERS:

- **PAYERS**
  - Claims histories
  - Actuarial models
- **MEDICAL GROUPS**
  - Trust assessment
  - Goal alignment evaluations

See "Who Do You Trust" MGMA Connexion, February 2013

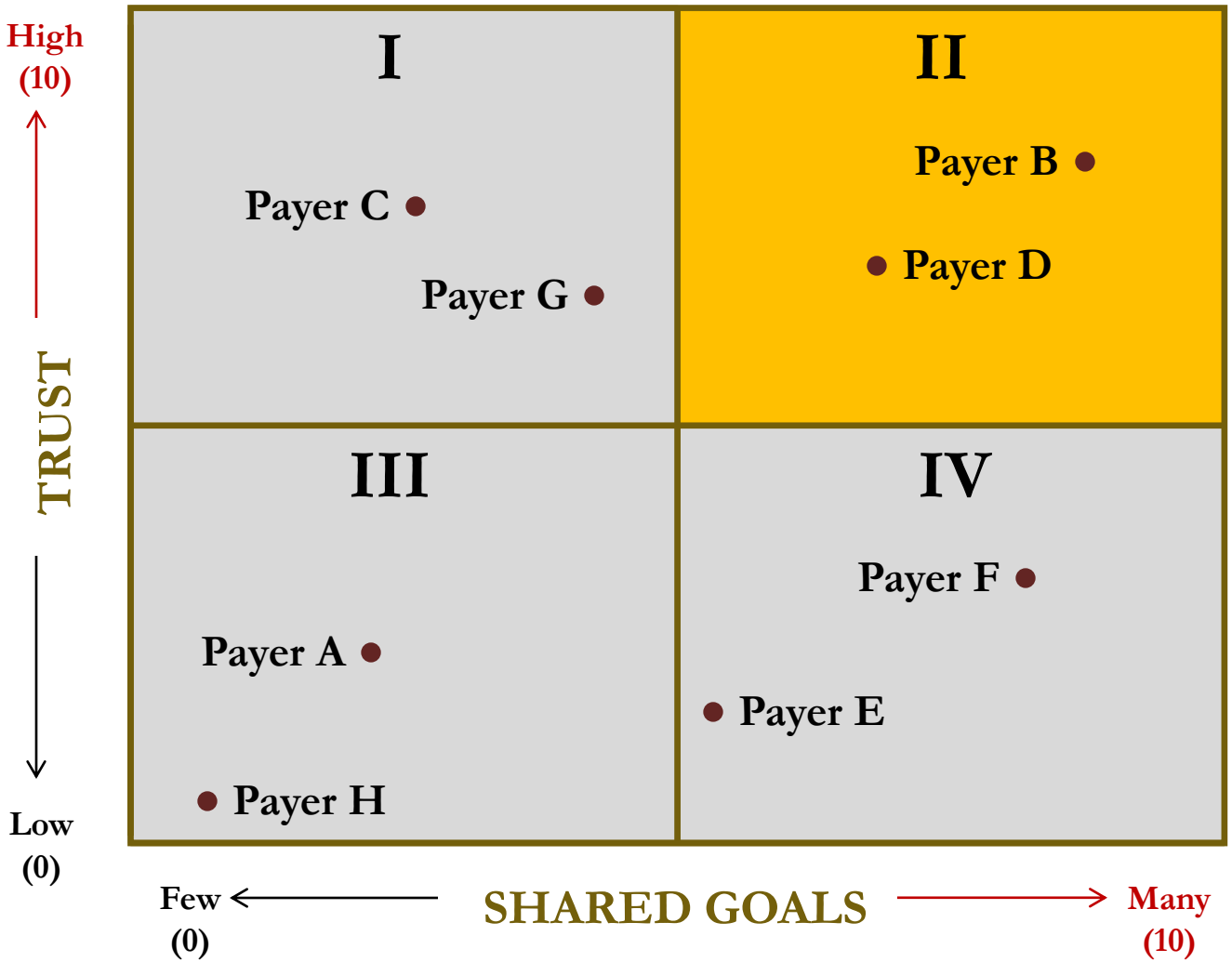
CONTRACTING PRIORITIES BY QUADRANT

ACCOUNTABLE CARE CONTRACTING MATRIX



CONTRACTING PRIORITIES BY QUADRANT

PRIORITY #1: QUADRANT II

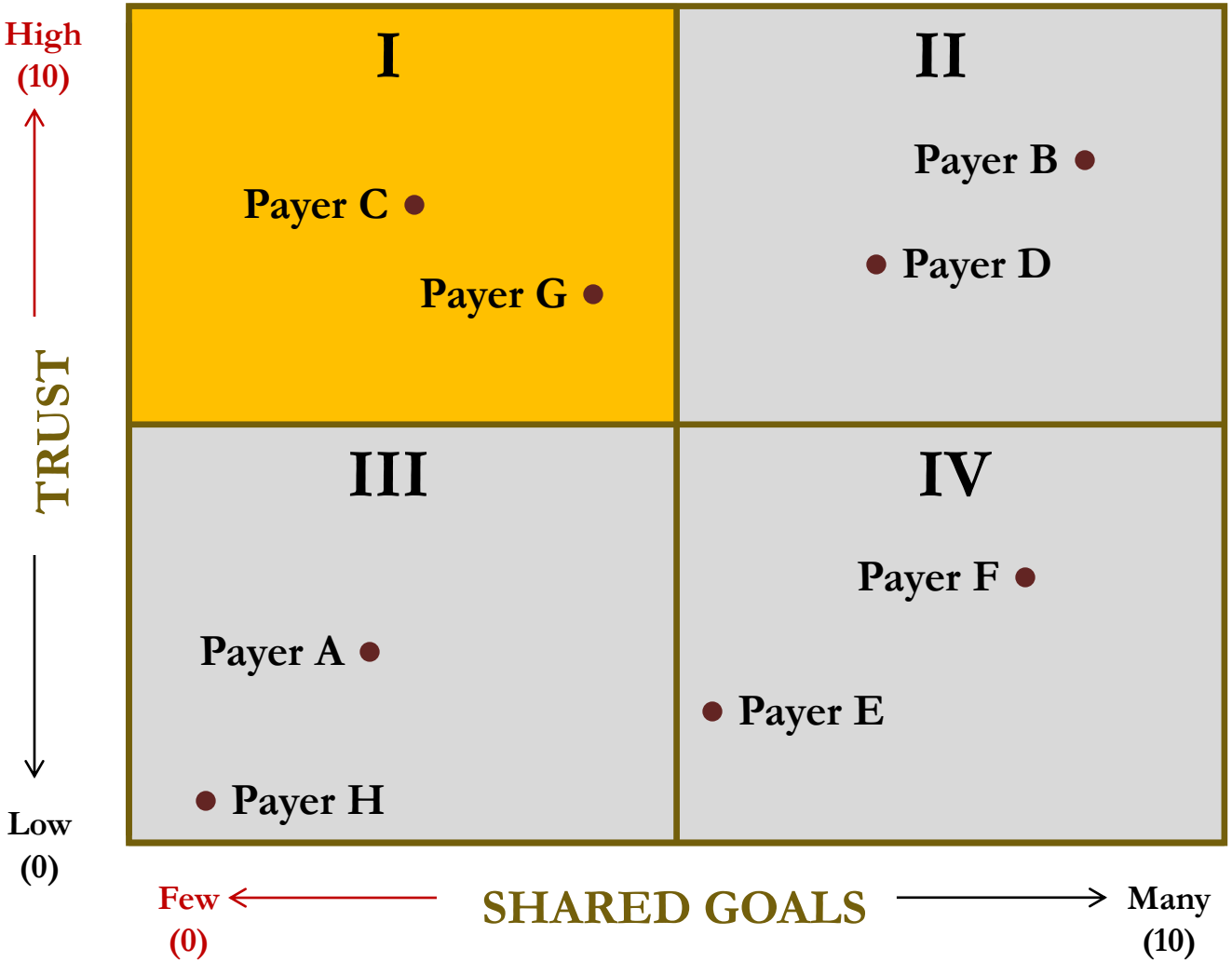


+ Negotiations can be quick and confident

+ Shared values and competencies

CONTRACTING PRIORITIES BY QUADRANT

PRIORITY #2: QUADRANT I

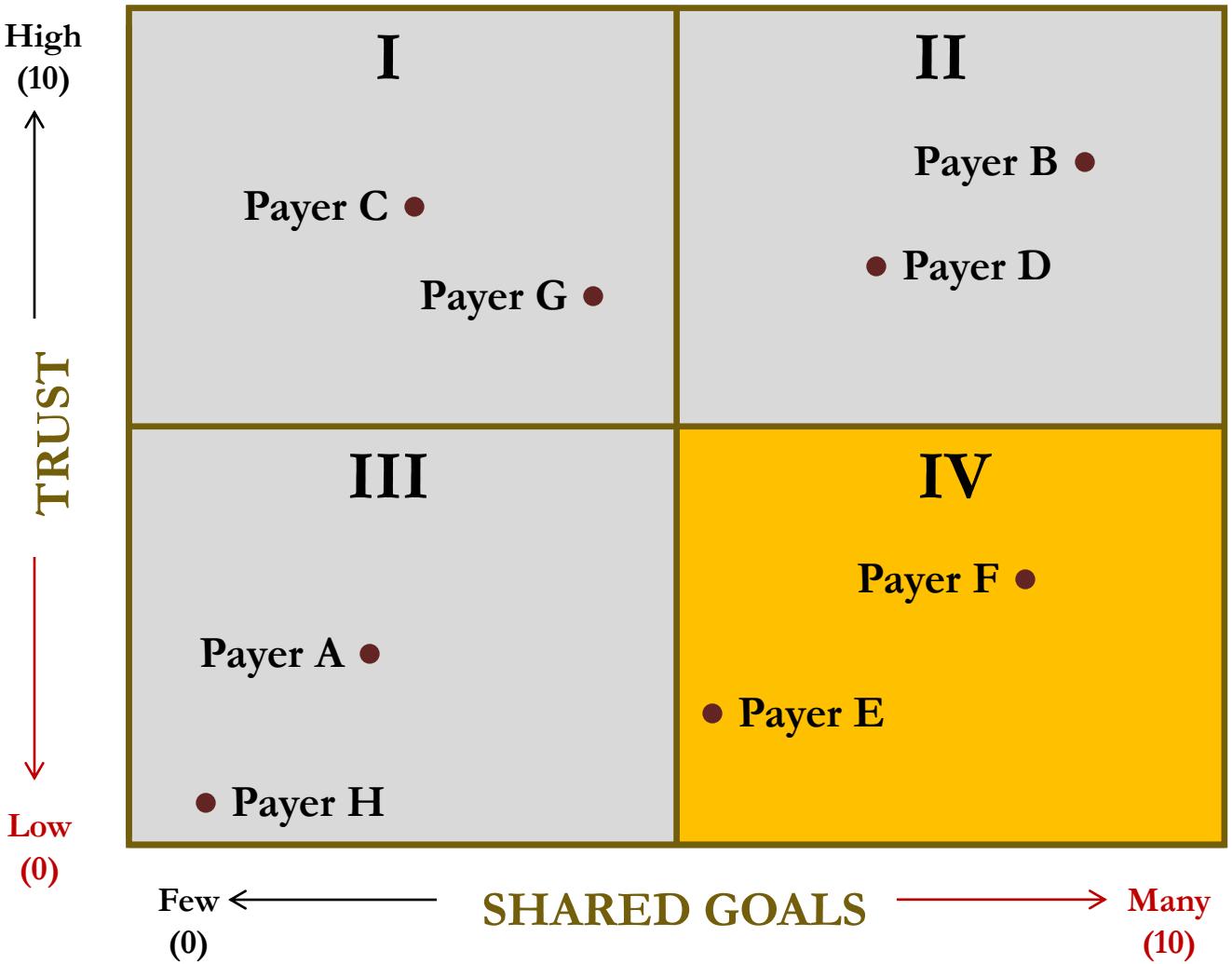


+ Good business history- high trust

- Needs to improve organizational processes

CONTRACTING PRIORITIES BY QUADRANT

PRIORITY #3: QUADRANT IV

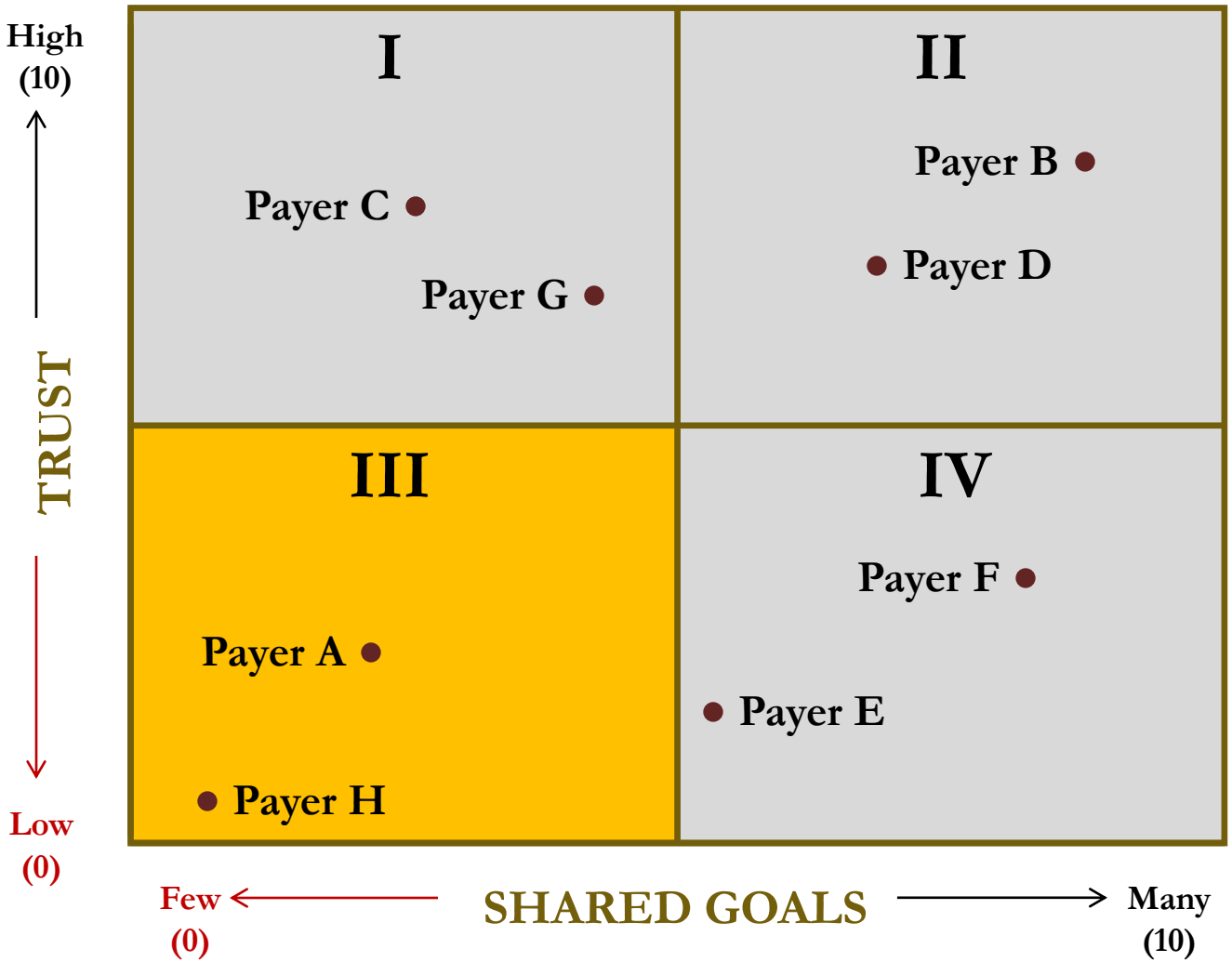


+ Accountable Care competencies in place

- Organizational cultures are in conflict

CONTRACTING PRIORITIES BY QUADRANT

PRIORITY # 4: QUADRANT III



- Cultures and processes not aligned

- Contract history not satisfactory

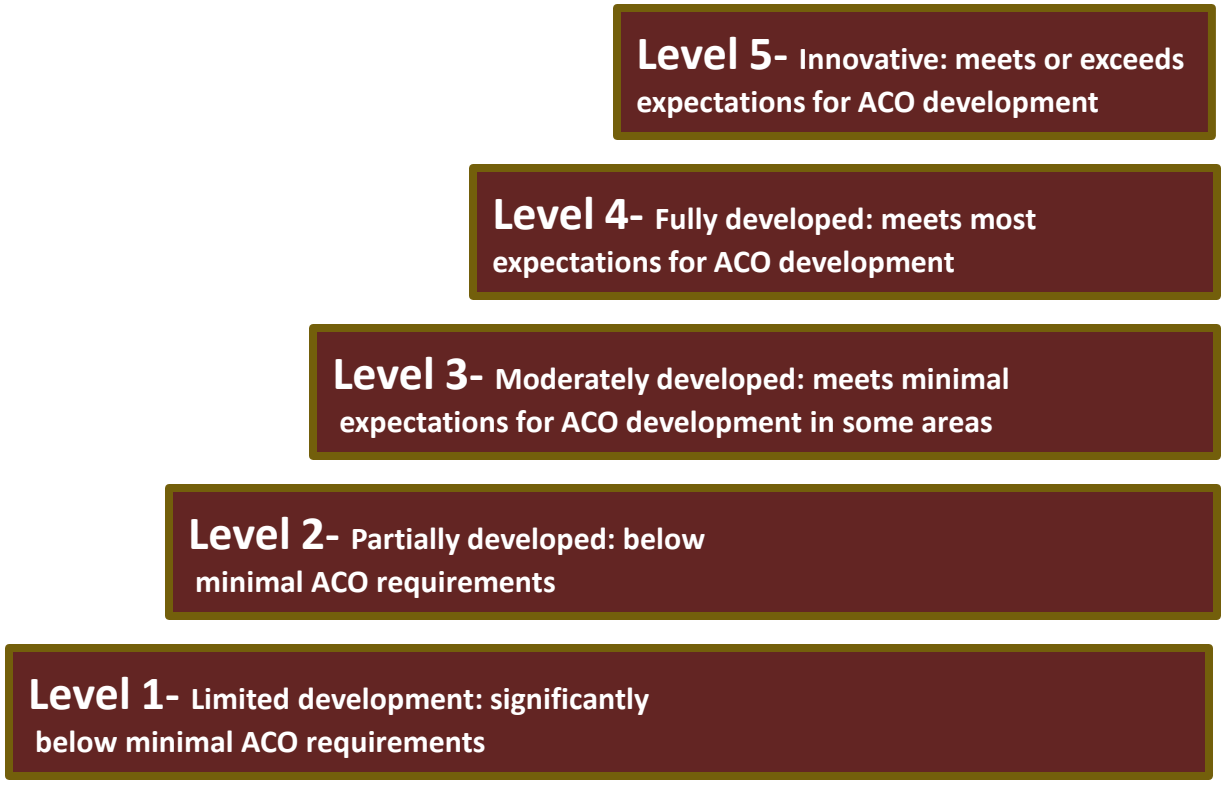
*** Consider Contract Termination**

CONCLUSION: ACO CONTRACTING ISSUES

- **ACO Readiness Assessment**
- **Summary**
- **Call to action**
- **Questions & Answers**

CONCLUSIONS: ACO READINESS ASSESSMENT

Levels of ACO Readiness



Source: Accountable Care Organizations, Bard & Nugent, 2011, pg. 289

CONCLUSIONS: ACO READINESS ASSESSMENT

ACO Readiness Assessment Chart

	Level 1	Level 2	Level 3	Level 4	Level 5
Leadership & Culture					
Operational Excellence					
Care Integration					
Physician Alignment					
Technology Enablement					
External Environment					
Recommendation					

Source: Accountable Care Organizations, Bard & Nugent, 2011, pg. 291

CONCLUSIONS: ACO READINESS ASSESSMENT

Example: Readiness for External Environment

- **Level 1**
  - Organizations which have less competitive urgency to pursue an ACO strategy
  - The real challenges lie within the organization rather than outside of it
- **Level 2**
  - Beginning to reach out to local payer organizations
- **Level 3**
  - Already approaching payers outside the normal negotiation cycle to think strategically about changes in the market
- **Level 4**
  - Currently coordinate plans with payers to pay for the data and tools to measure avoidable costs, reduce those avoidable costs, and align incentives to share and sustain savings
- **Level 5**
  - Market leaders who set the standards and pace for their markets
  - Payers compete with other payers to steer business to these high-quality, low-cost providers

Source: Accountable Care Organizations, Bard & Nugent, 2011, pp. 295-303

SUMMARY

- **ACO CONTRACTING ISSUES**
- **LEARNING OBJECTIVES**
  - I. **Assess the trust level of each ACO contracting payer**
  - II. **Identify criteria to use in aligning payer-provider goals and values**
  - III. **Establish contracting priorities and develop negotiation strategies**
- **ACO READINESS ASSESSMENT**

CALL TO ACTION

- **Assess internal capabilities & resources**
  - Time availability
  - Internal expertise
  - Analytic tools & resources
  - ACO Readiness Assessment results
- **Determine what should be outsourced**
  - Readiness criteria development
  - Strategic payer negotiations
  - Payer relationship evaluations
  - Contracting priorities and strategies

Q & A

LEARNING OBJECTIVES

I. **Assess the trust level of each ACO contracting payer**

II. **Identify criteria to use in aligning payer-provider goals and values**

III. **Establish contracting priorities and develop negotiation strategies**

HOW TO PREPARE FOR ACCOUNTABLE CARE CONTRACTING: PRIORITIES AND NEGOTIATIONS

For more information about Reliance Consulting Group,
visit: **www.RelianceCG.com**
Or
Contact Dr. Schmitt directly: **jschmitt@reliancecg.com**

Please visit our booth in the exhibit hall!