The Role of Accountable Care Organizations in Community Health Improvement

Patrick Charmel, President & CEO, Griffin Health Services

National Operating Environment

- Volume to Value
  - Unsustainable escalation of healthcare costs and public demand for increased quality and safety driving value based payment incentives
  - Aging of the U.S. population increasing chronic disease prevalence
- Increased Employer and Consumer Engagement
  - Employers pushing much of the cost burden to consumers (average employee now pays 40% of healthcare cost)
  - Increased pricing and quality transparency empowers consumers and motivates providers
- New Set of Core Competencies is Required For Provider Success Going Forward in Healthcare's New Era

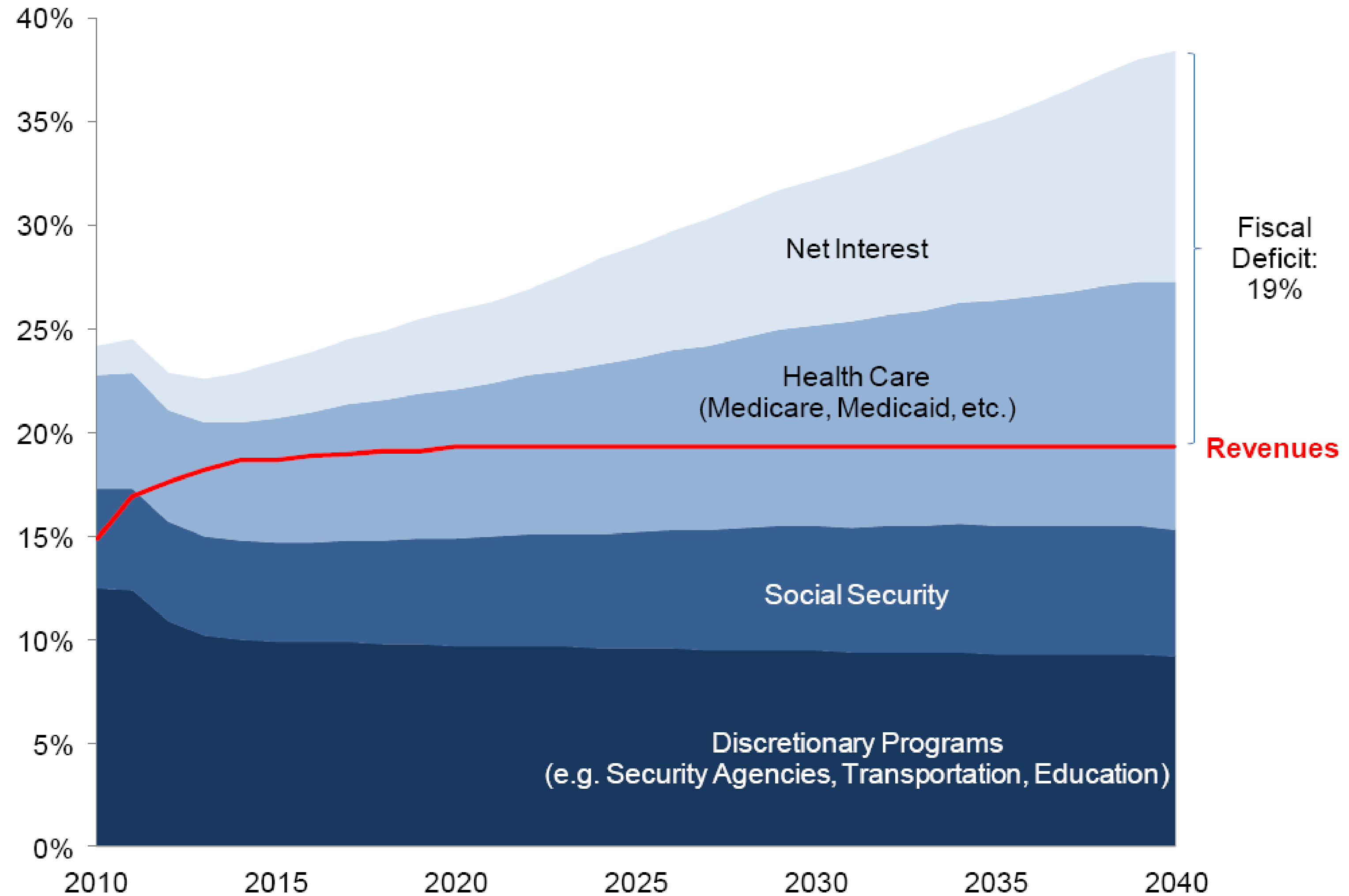
Transformational Change

A Burning Platform

Healthcare Costs Threatening to Bankrupt the Nation

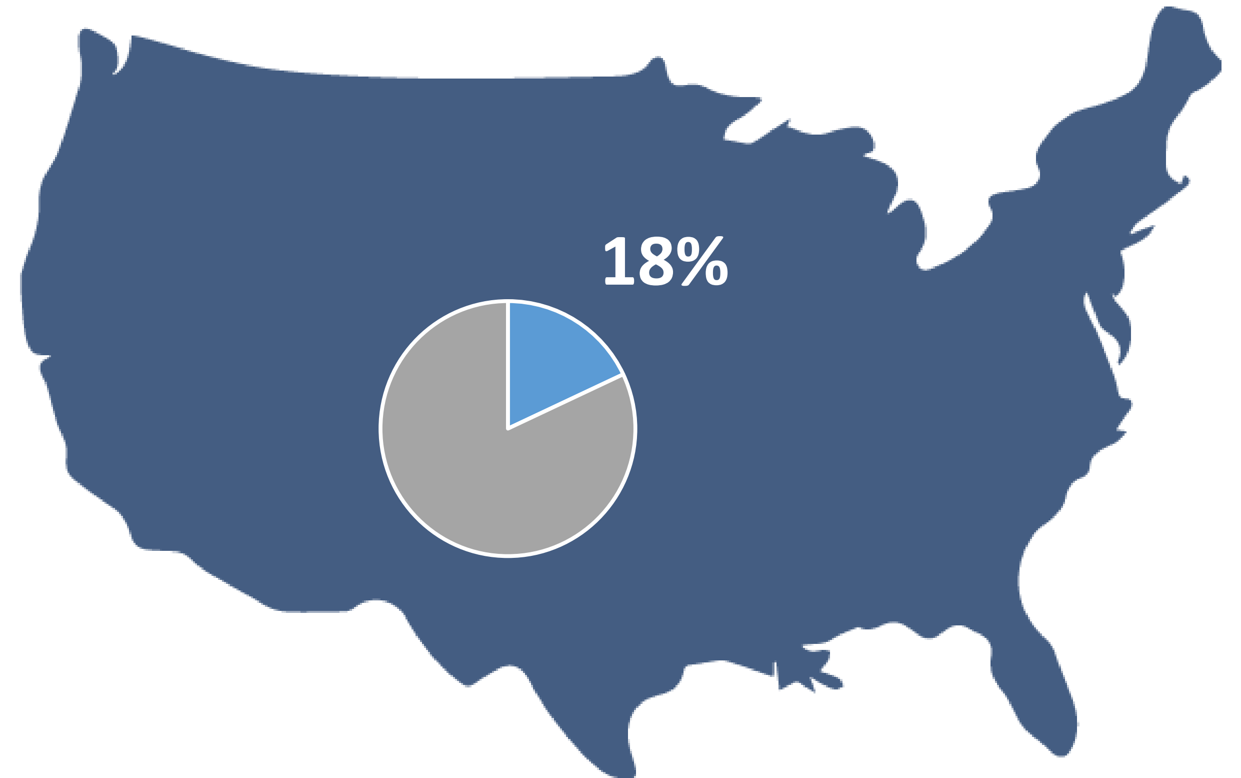
Federal Government Outlays & Revenue
% of GDP.

Congressional Budget Office scenario based on Expected Law
2010-2040



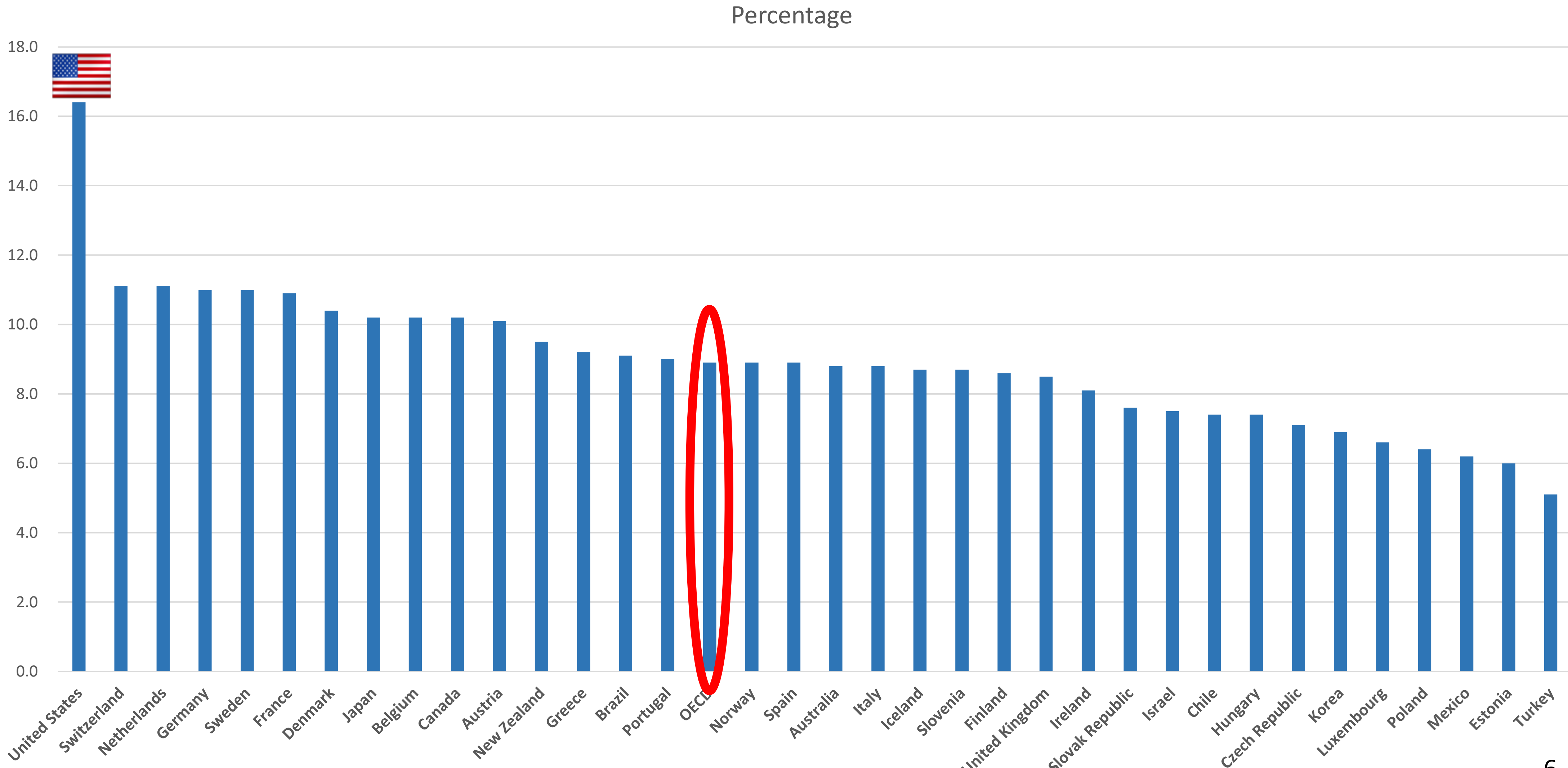
Core Problem that Needs to be Addressed

National health expenditures accounted for 18% of the GDP in 2015, and are expected to increase to 20% by 2025. This is a crippling problem to the U.S. economy and presents a major spotlight in the political environment.



Source: Rock Health, StartUp Health, Accenture, Markets and Markets, CMS.gov, Forbes.

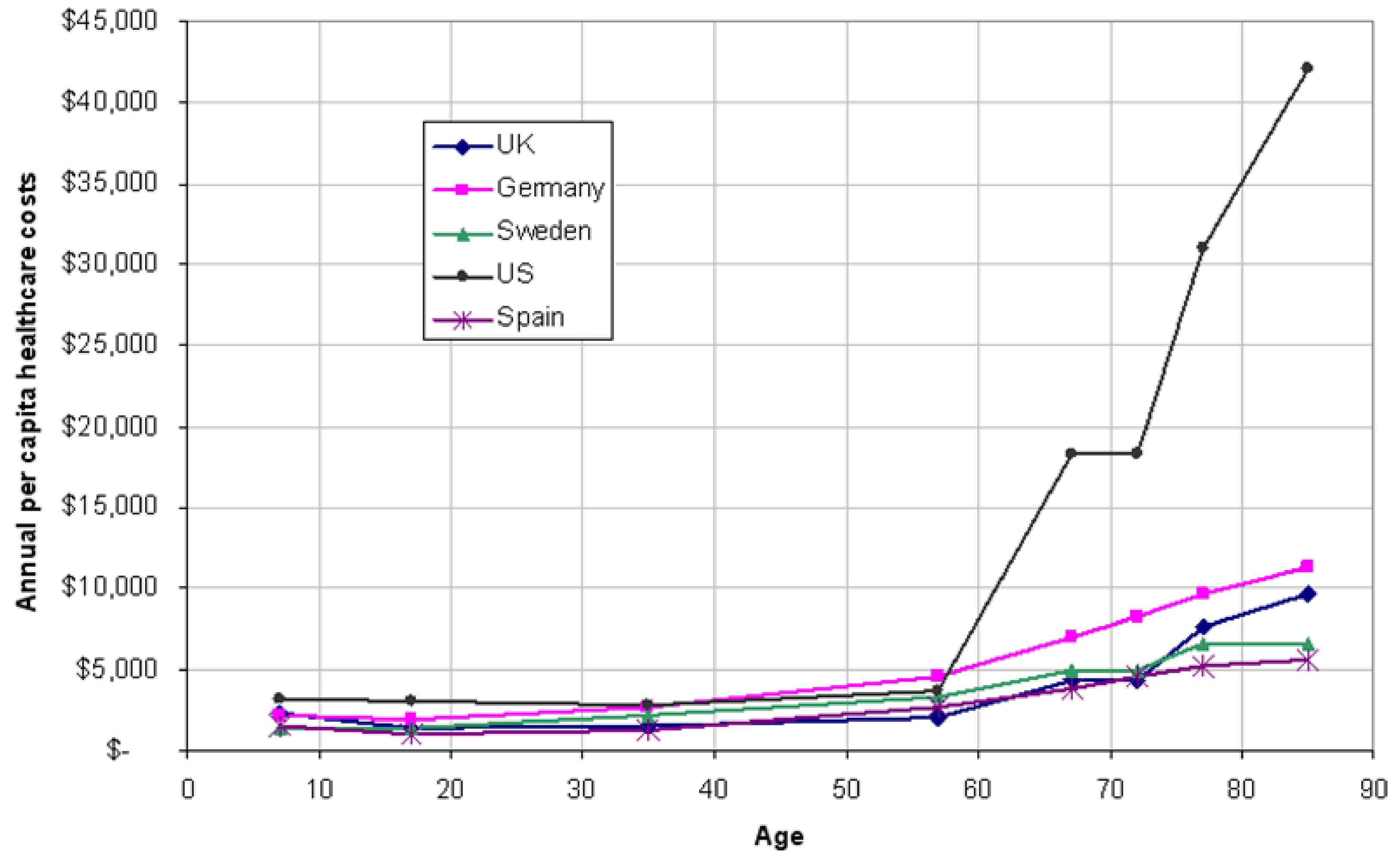
Health Expenditures as % of GDP, 2013



Healthcare Costs are Unsustainable

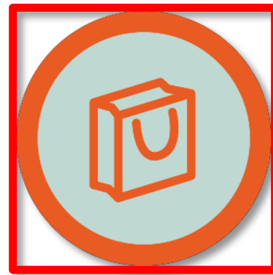
Costs by Age

The U.S. is spending much more for older adults



What Determines Health?

Social Services



job training and employment programs

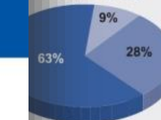
supportive housing & rent subsidies

nutritional support & family assistance

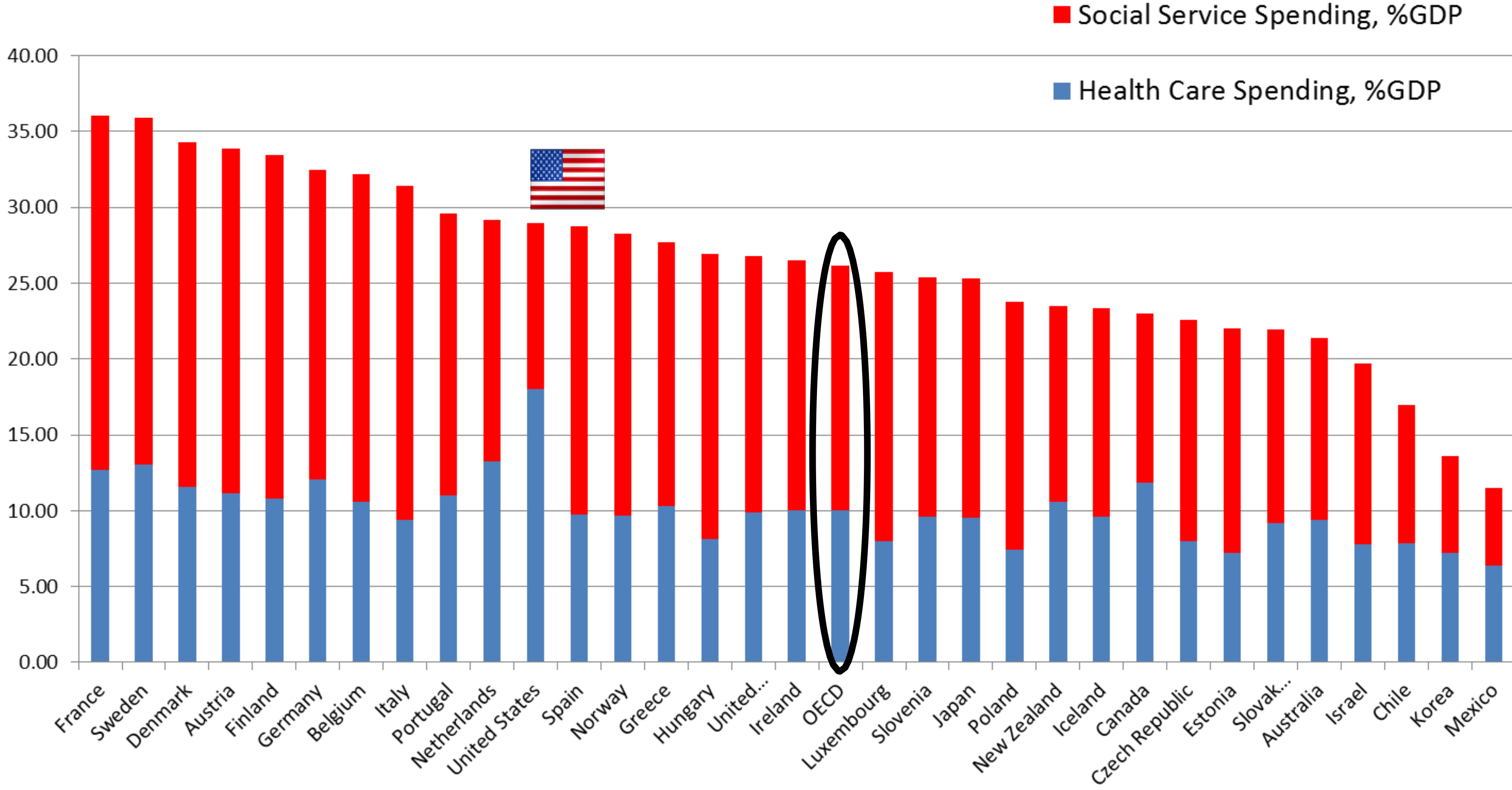
other social services that exclude health benefits

United Way ALICE Report

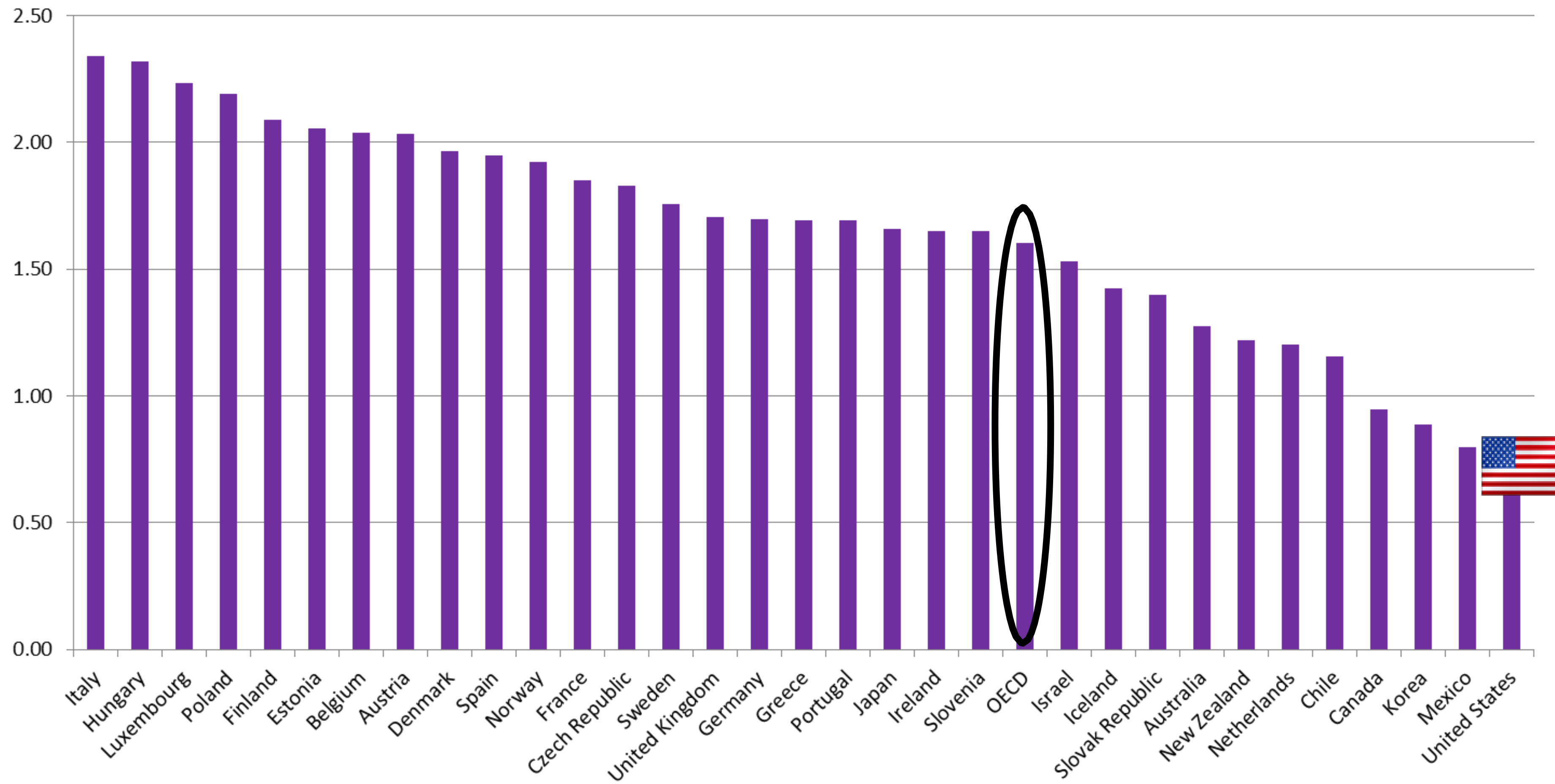
United Way ALICE report highlights state and local residents' ability to meet basic food and housing needs as a community-wide issue.



Total Investment in Health as of % of GDP



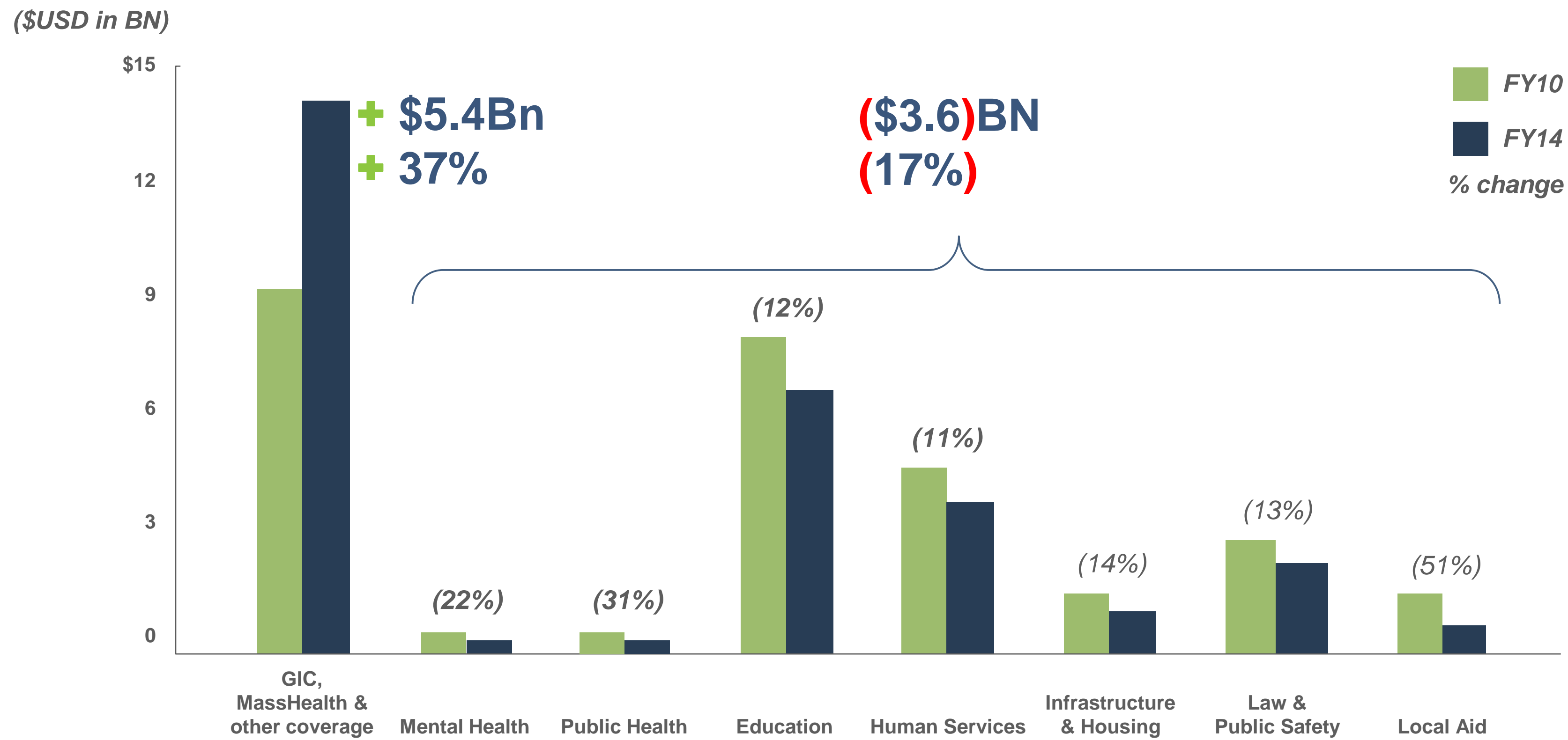
Ratio of Social Service to Health Care Spending



*Switzerland and Turkey are missing data for 2009

The Massachusetts Experience

Significant healthcare spending at the state level has come at the expense of other public needs



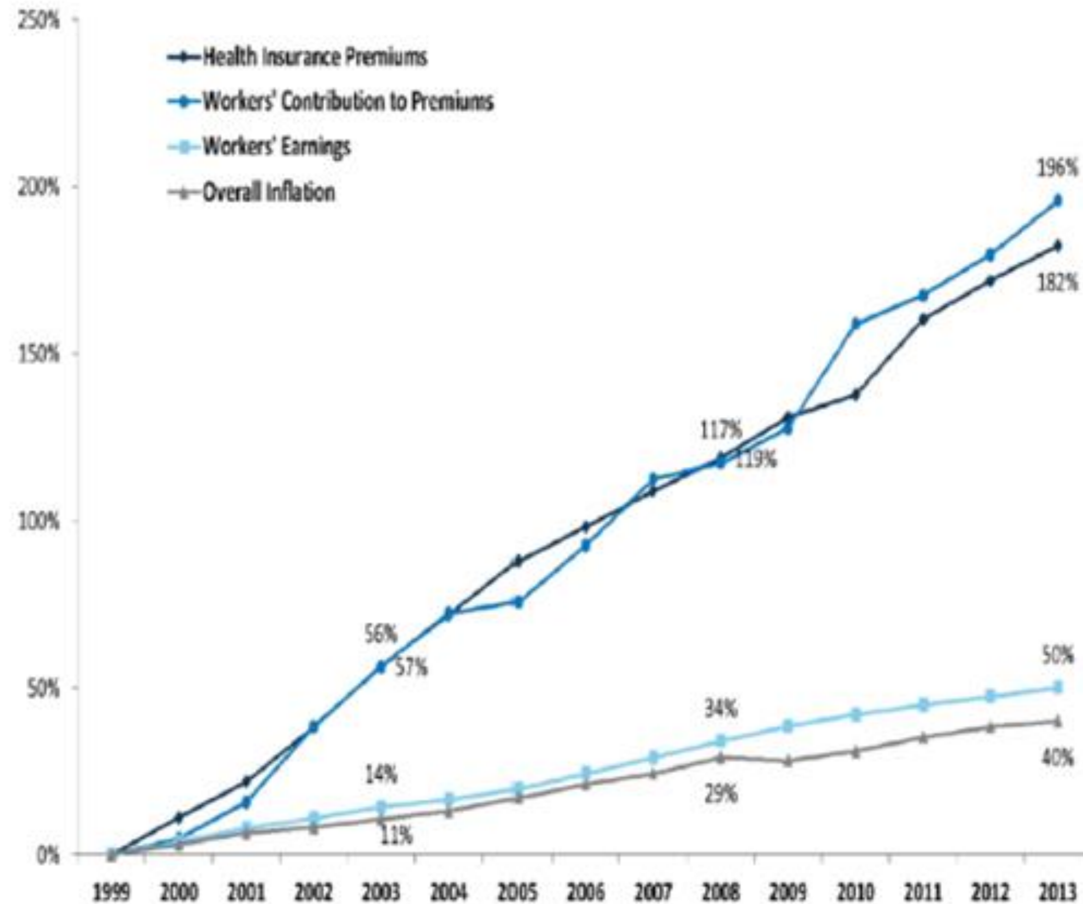
Source: Massachusetts Budget and Policy Center; figures adjusted for GDP growth.

Rising private health insurance premiums prompting employers to shift plan costs to employees via increased premium share, co-pays and deductibles

Insurance Premiums

Upward trend:

Cumulative increases in health insurance premiums and worker's contribution outpace increases in worker's earnings and inflation 1999-2013



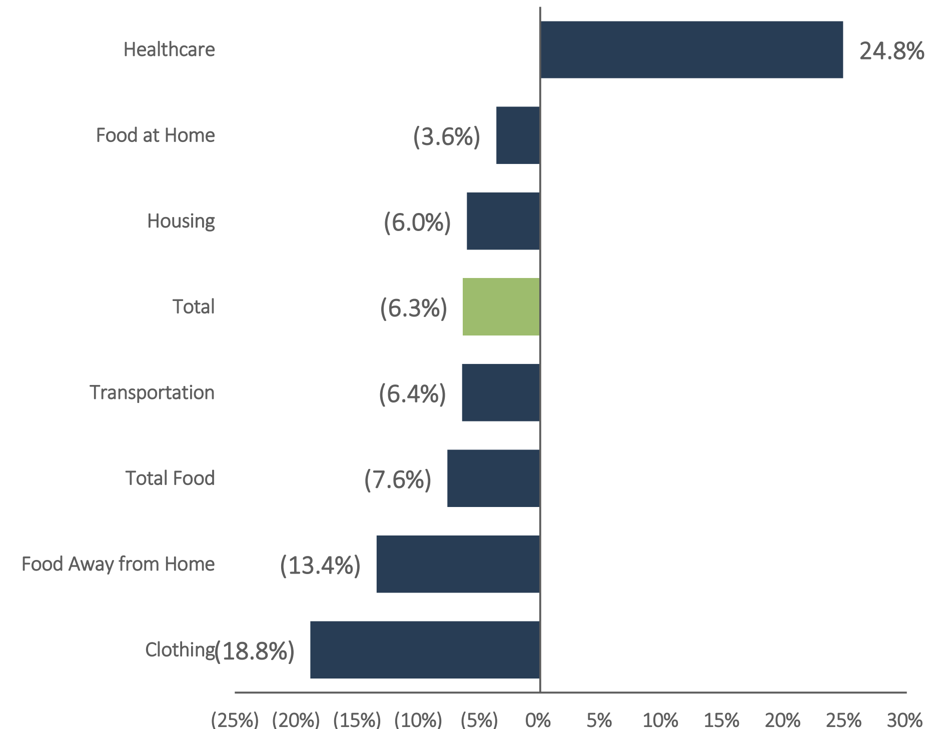
SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2013. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 1999-2013; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 1999-2013 (April to April).

Healthcare Continues to Consume a Larger Percentage of an Individual's Paycheck

Wage stagnation, coupled with escalating healthcare costs has led individuals and families to spend a greater proportion of take-home income on healthcare

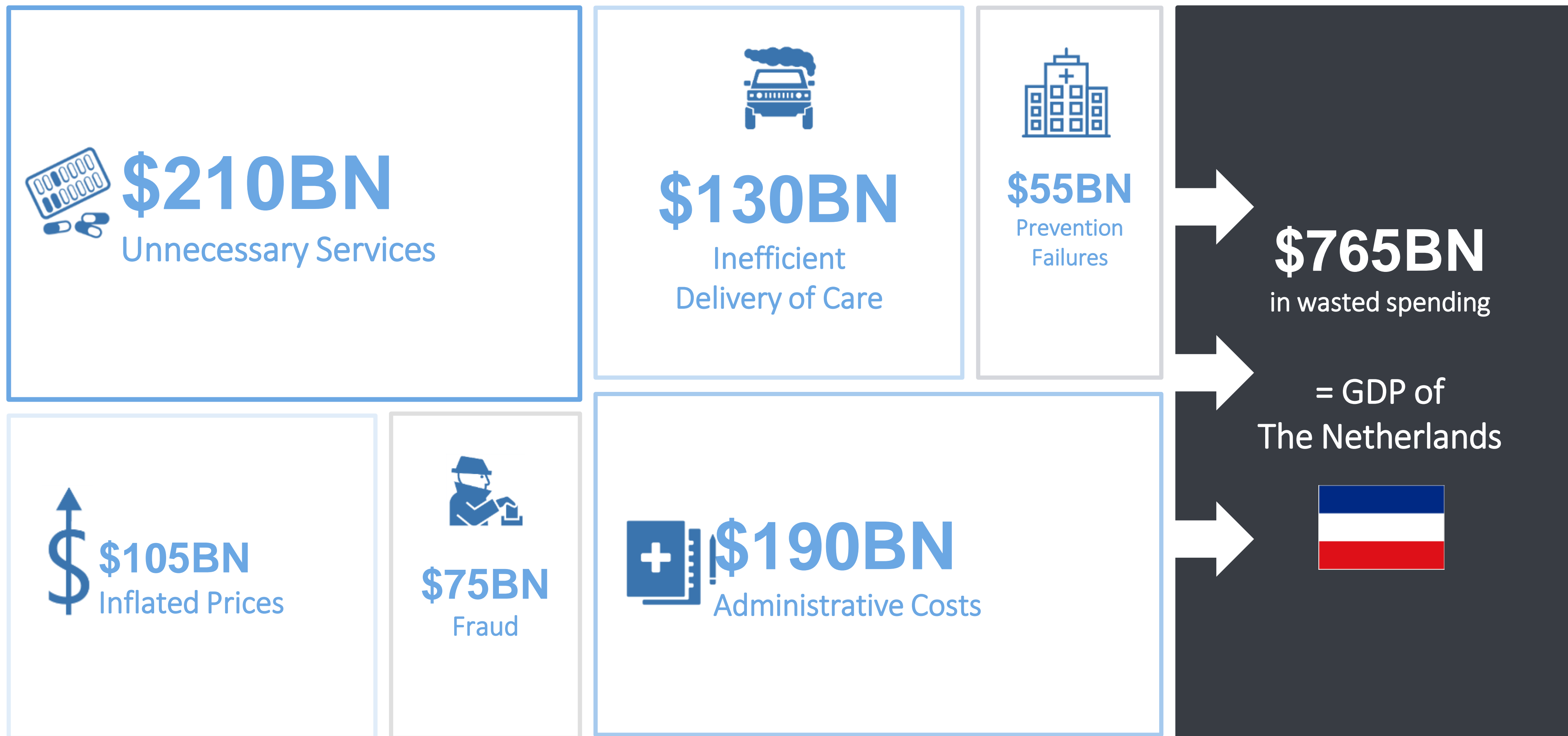
> Millennials entering the workforce now can expect to spend roughly half their lifetime earnings on healthcare.

> Middle-class families' spending on healthcare increased 25% from 2007 through 2015 as other basic needs fell by the wayside.



Source: Brookings Institution Analysis of Consumer Expenditure Survey, Labor Department, Wall Street Journal, Catastrophic Care.

Volume Based Incentives, Lack of Effectiveness and Inefficiency Resulting in Tremendous Waste



Source: Institute of Medicine (2009 data); The World Bank (2009 data).

Additional Forces Driving Change

- Demographics
- Rush for greater provider accountability for cost and quality of care
- Concerns about care fragmentation
- Rush to eliminate care variation
- Demand for transparency of cost, quality and community benefit data
- Employer and consumer resistance to increased premiums and higher deductibles
- Difficulty in raising capital
- Federal and state reform & legislation
- Reimbursement decline

Transformational Change

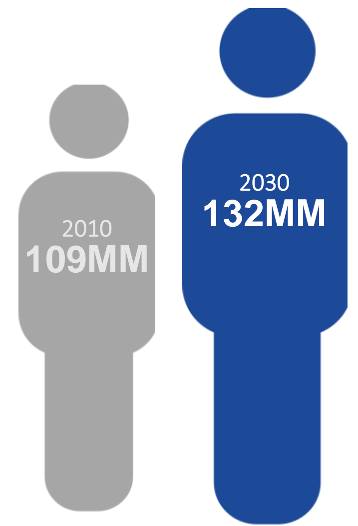
- Demographics

Aging of the population increasing chronic disease prevalence

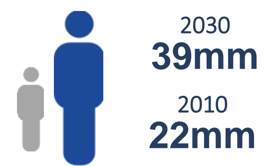
Our Population is Aging and Becoming Sicker

As the baby boomer generation ages, the country has become older and sicker, creating a greater need for a strong healthcare system to manage the shifting demographics

> The U.S. population aged 50+ is expected to grow to 132MM...



...and the number aged 65-74 will nearly double

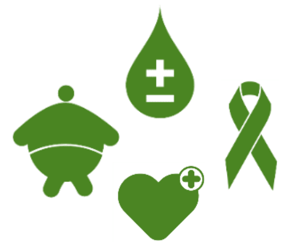


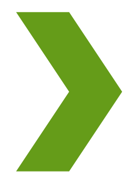
Age 50+

Age 65-74

> Chronic disease is an epidemic that is expected to worsen...

	2010	2030
TOTAL(MM)	**149MM**	**171MM**
PROPORTION	**48%**	**49%**



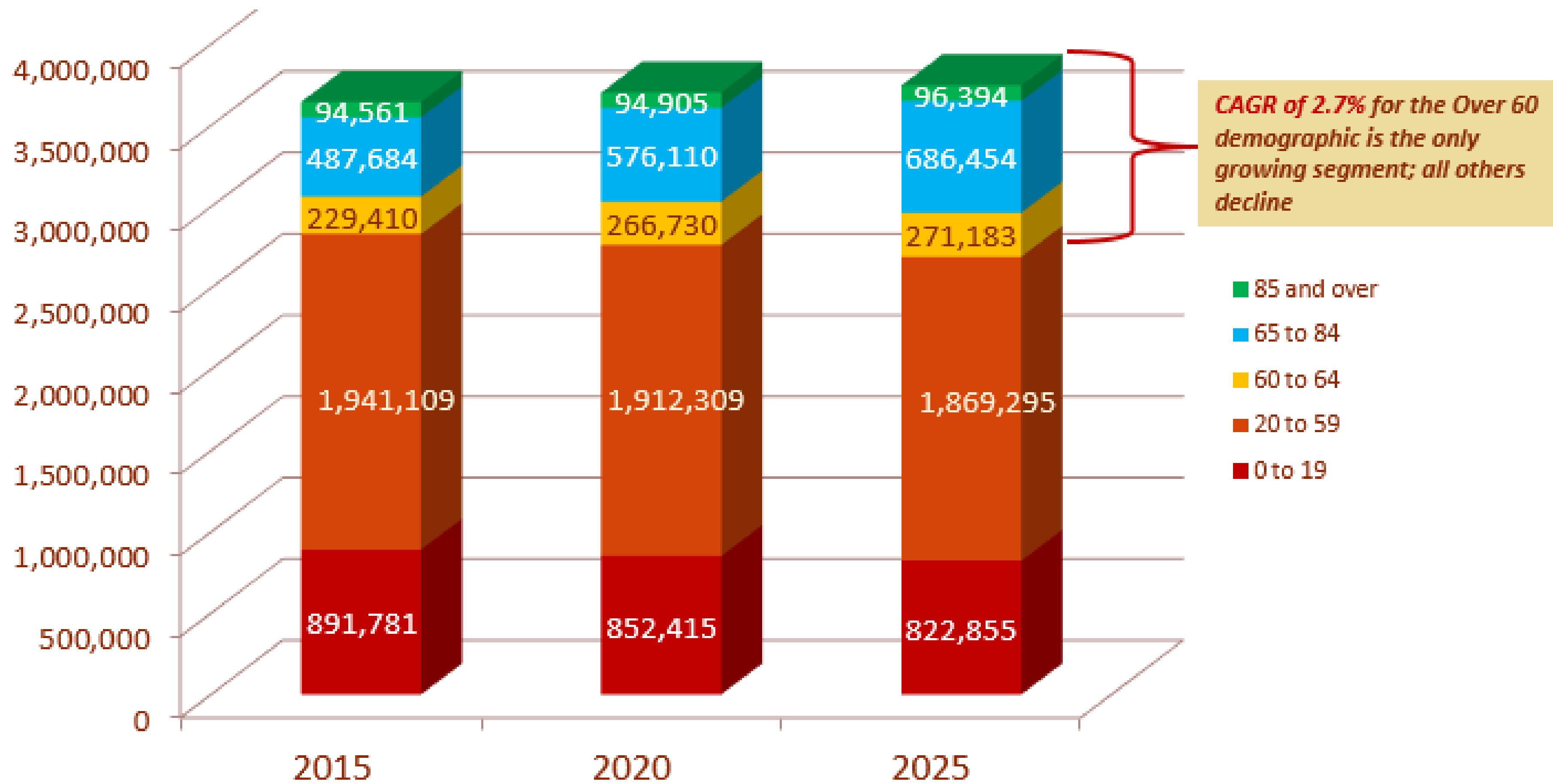


$0.75 of every $1 spent

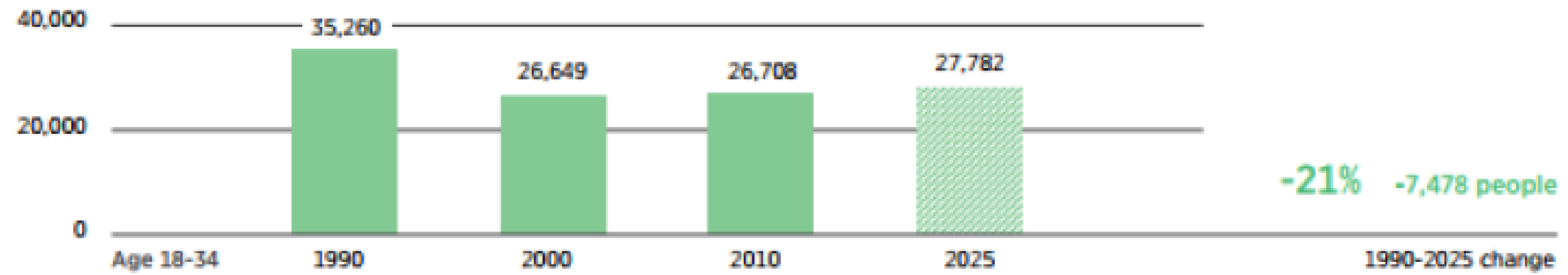
...and account for the vast majority of healthcare expenditures

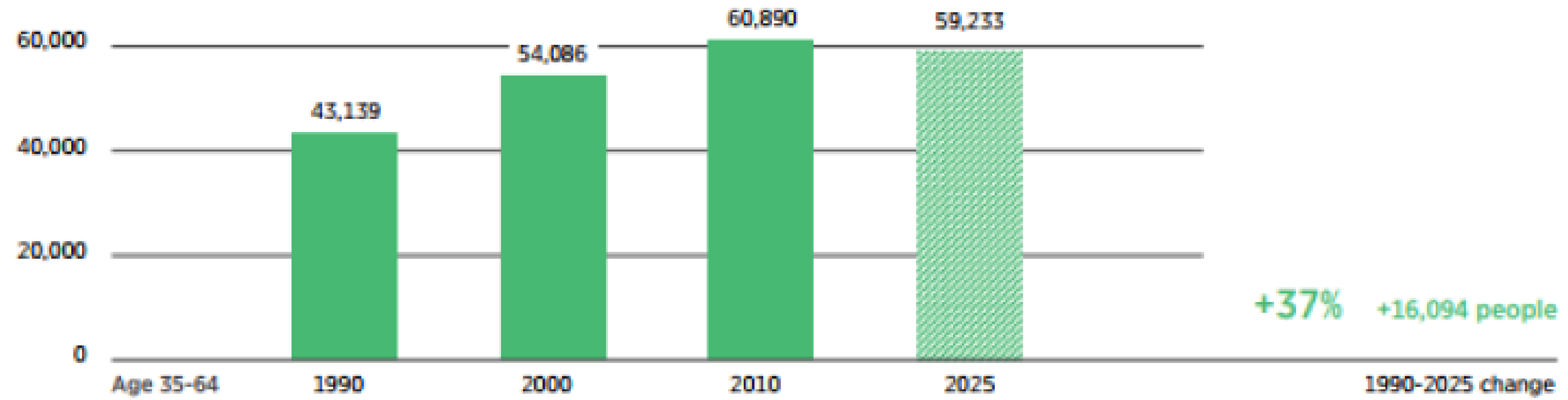
Connecticut Population Growth Projections

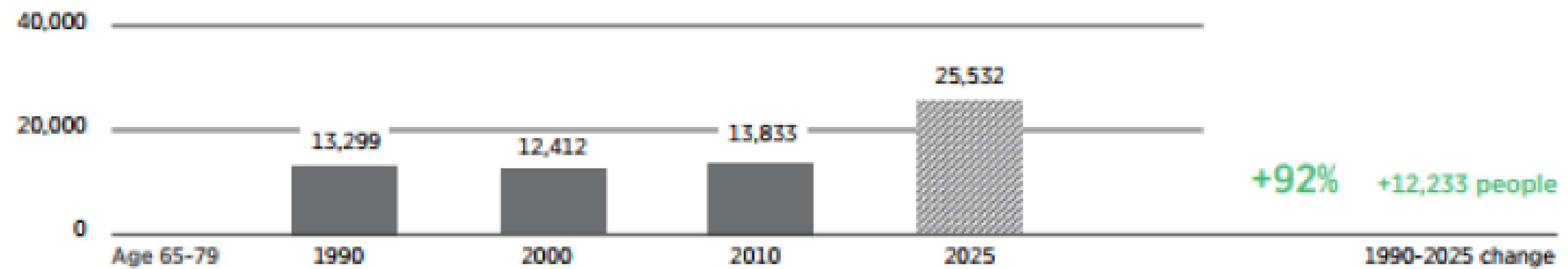
Growth will come in the 60+ demographic

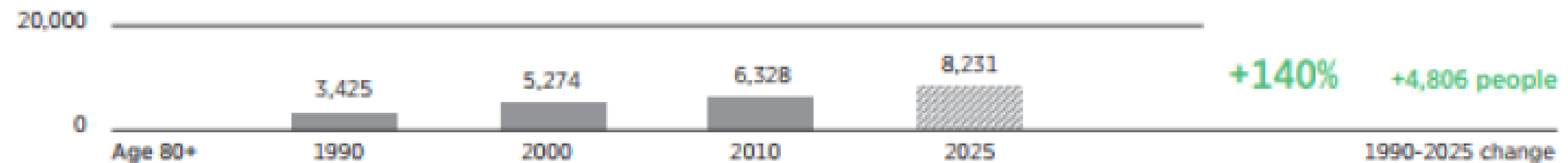


Connecticut and the Valley aging faster than the U.S.



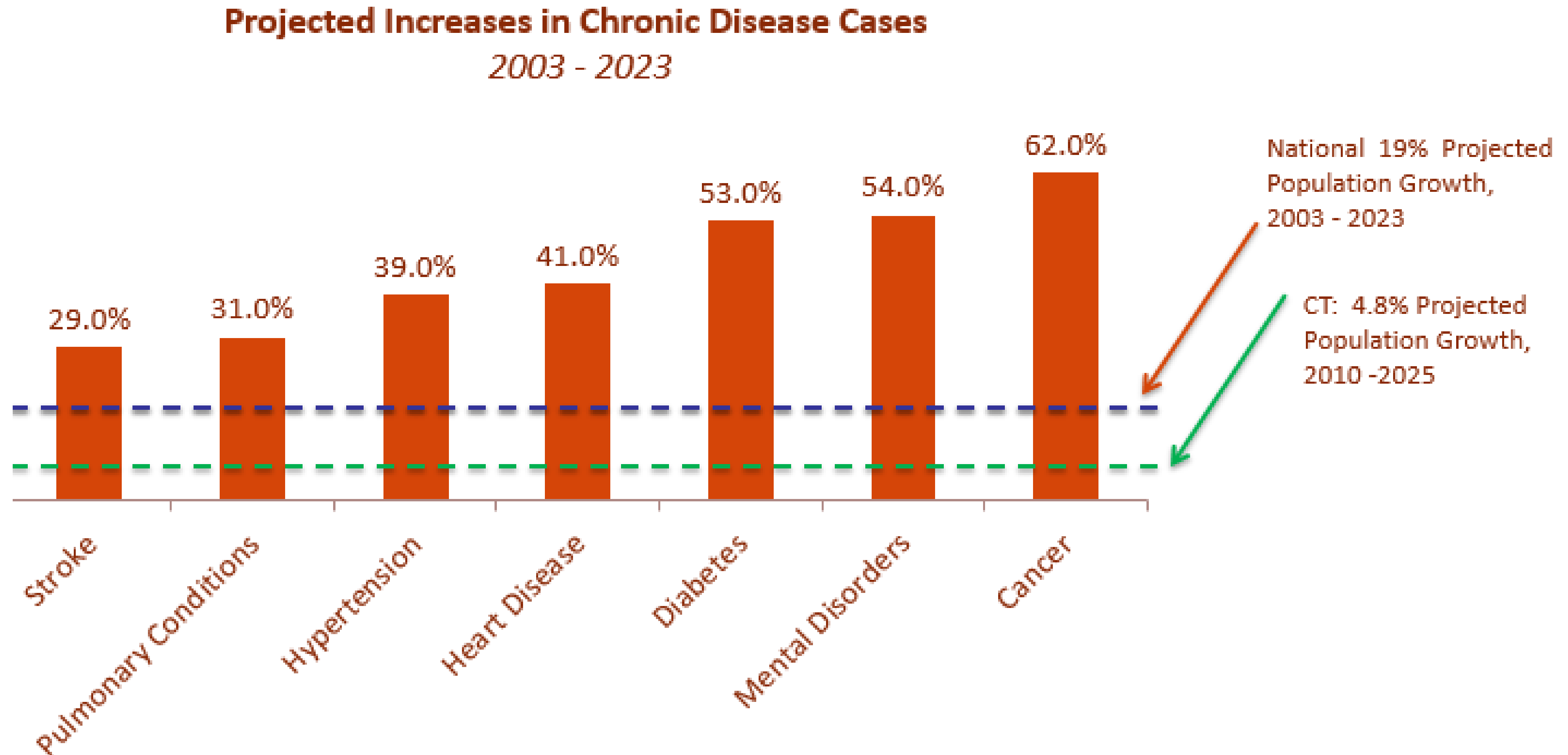






Growth Area: Chronic Disease

Chronic Disease Growth Outpacing Population Growth



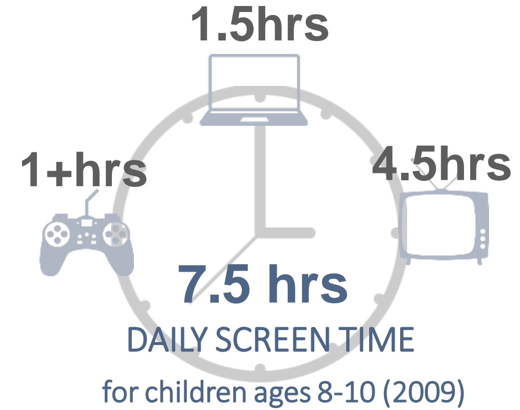
A Sedentary Lifestyle and Unhealthy Diet are Fueling the Growth in Chronic Disease

Americans consume too much sugar and high calorie foods, creating a toxic environment of cheap, unhealthy options which has led to a steep climb in obesity

# of TVs in homes has QUADRUPLED

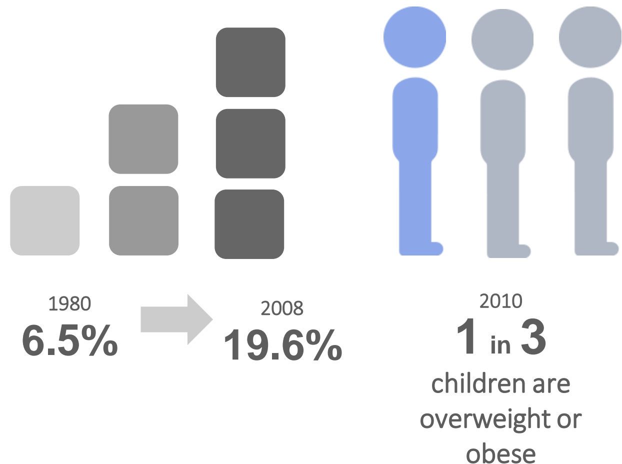
# of foodservice establishments has DOUBLED

Soda consumption has DOUBLED in girls, and TRIPLED in boys

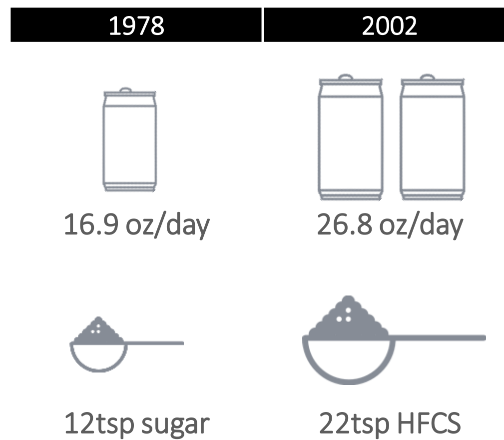


DAILY SCREEN TIME for children ages 8-10 (2009)

Obesity in children aged 6-11



Soft drink consumption has spiked

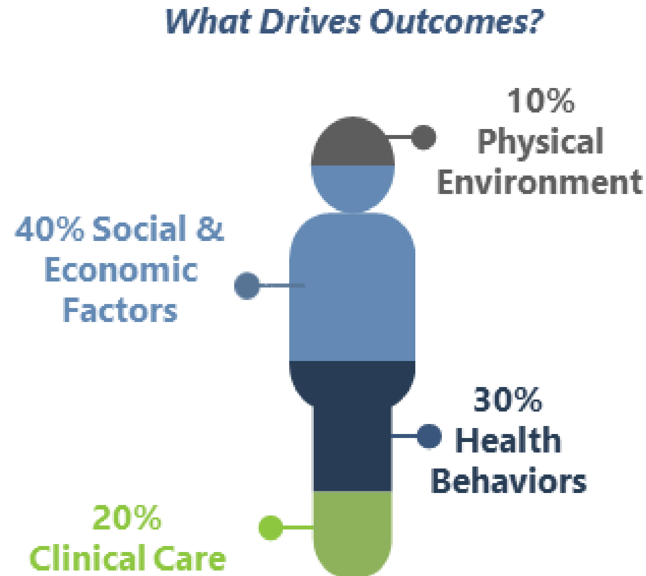


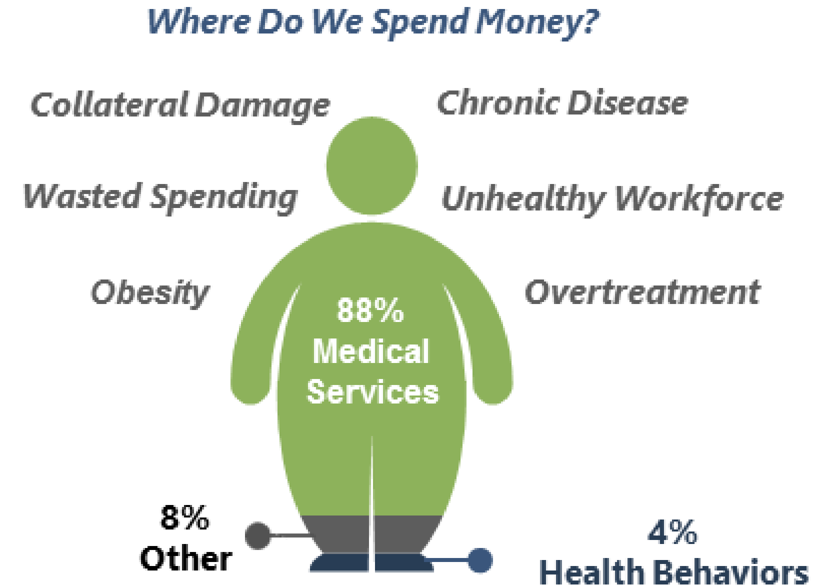
> For every additional serving above the USDA's recommended 12 tsp sugar per day, a child is 60% more likely to become obese.

Source: CDC; Whitehouse.gov.

Current spending Not Targeted at Improving Outcomes

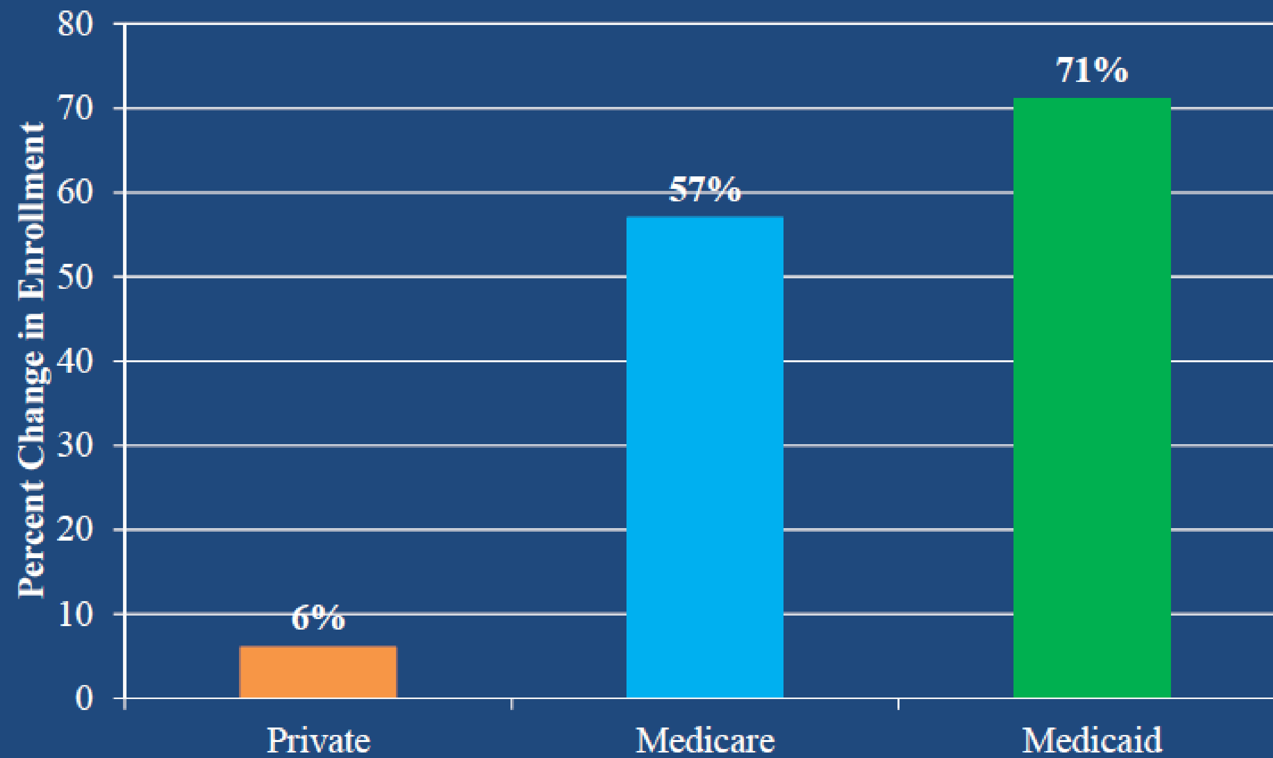
The average consumer spends less than 0.01% of their life in clinics, yet healthcare spending accounts for nearly 20% of the GDP. In an era of shifting care models, providers can no longer be successful by simply providing paid services; rather, they must also achieve outcome success.





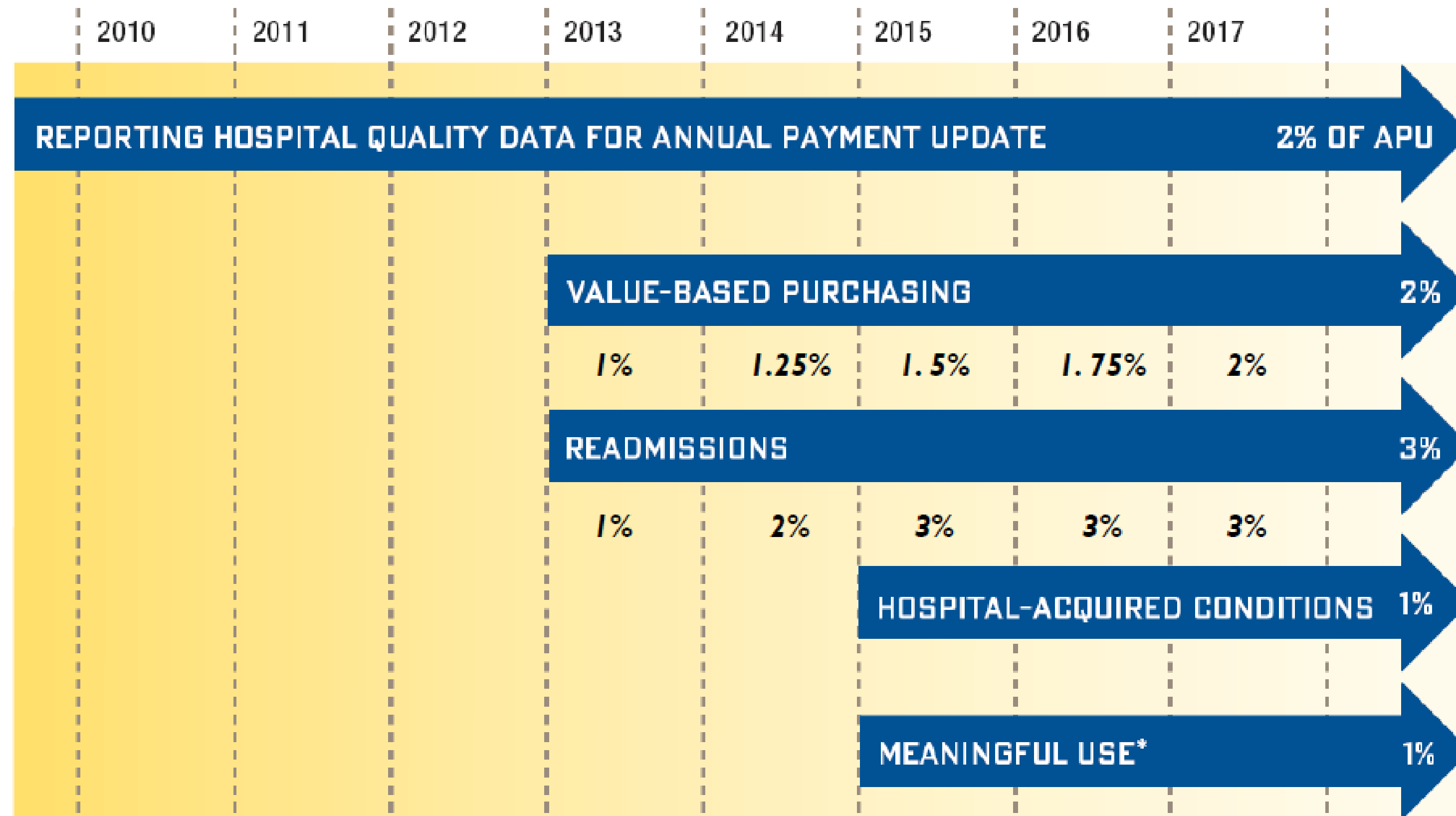
Source: Rock Health, StartUp Health, Accenture, Markets and Markets, CMS.gov, Forbes.

Growth Area: Medicare & Medicaid

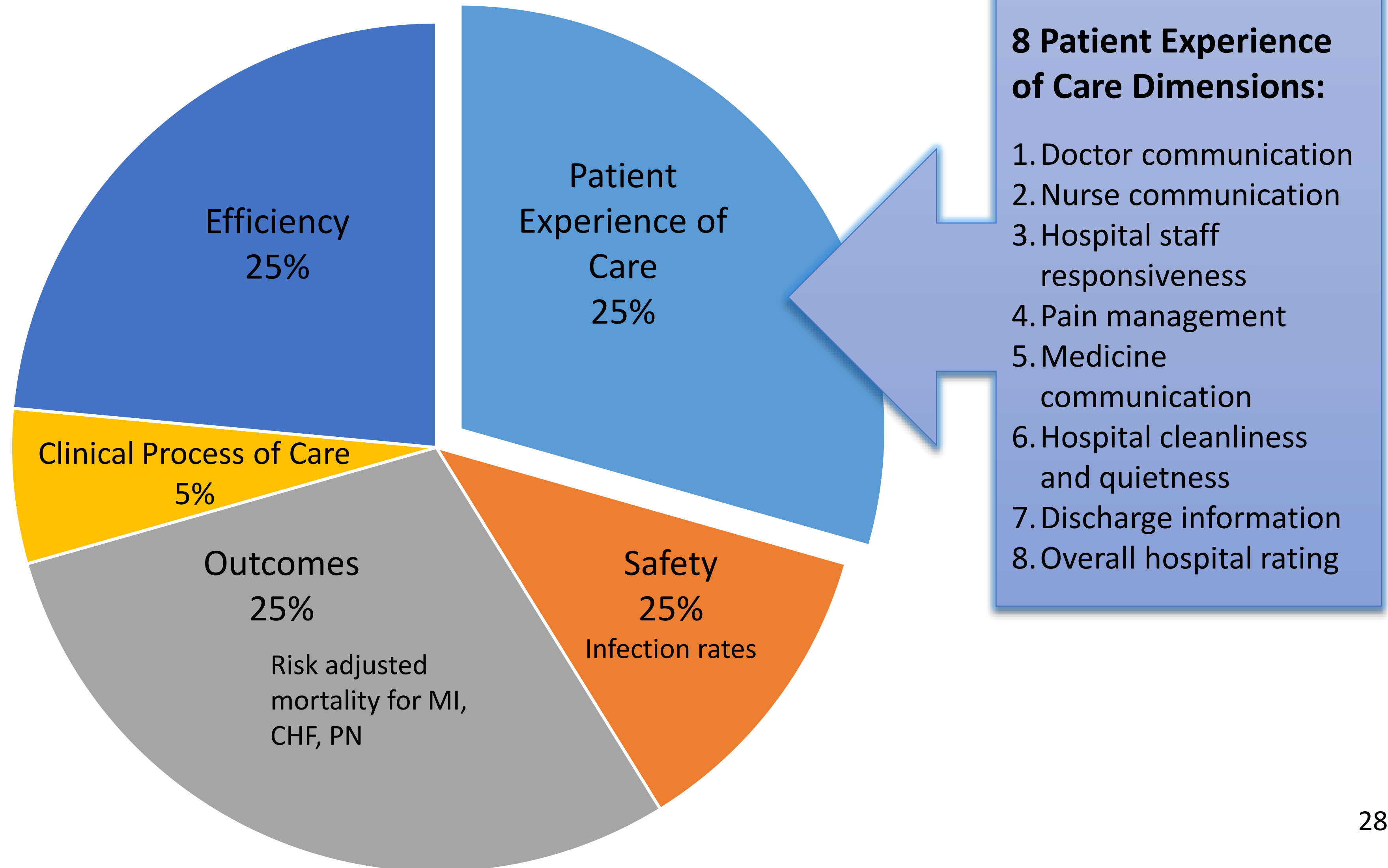


Medicare: Changing Provider Incentives to Bend the Cost Curve

Payments At Risk



2017 value based purchasing domains



Medicare readmission reduction program

Condition	2016 Crude National Rate
Acute Myocardial Infarction	17.8%
Chronic Obstructive Pulmonary Disease	20.7%
Heart Failure	22.7%
Hip/knee Arthroplasty	5.2%
Pneumonia	17.3%

Hospital-Acquired Condition (HAC) Reduction Program

CMS has categorized HAC measurements in two domains:

Domain 1 includes the AHRQ PSI-90 composite measure consisting of these indicators:	
PSI 3	Pressure ulcer rate
PSI 6	Latrogenic pneumothorax rate
PSI 7	Central venous catheter-related blood stream infection rate
PSI 8	Postoperative hip fracture rate
PSI 12	Postoperative pulmonary embolism (PE) or deep vein thrombosis rate (DVT)
PSI 13	Postoperative sepsis rate
PSI 14	Wound dehiscence rate
PSI 15	Accidental puncture and laceration rate

Domain 2 consists of the Center for Disease Control and Prevention's NHSN (National Healthcare Safety Network) CAUTI and CLABSI measures. CAUTI is catheter-associated urinary tract infection and CLABSI is central-line associated blood stream infection.

For CMS scoring Domain 1 weights 35% and Domain 2 weights 65%

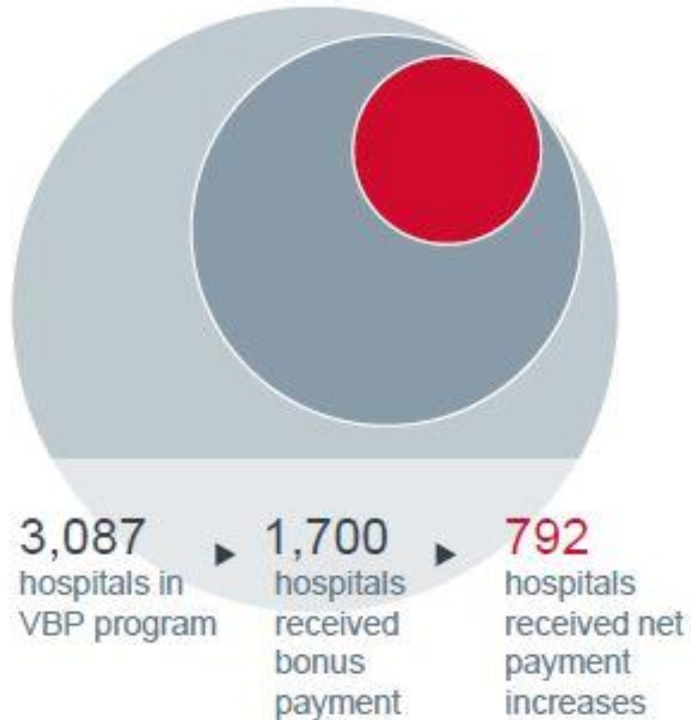
Hospital Acquired Conditions Score

Hospital	HAC Score	Payment Reduction
Bristol Hospital	2.85	No
Sharon Hospital	4.03	No
Griffin Hospital	4.26	No
Backus Hospital	4.91	No
Rockville Hospital	5.54	No
St. Vincent's Medical Center	5.62	No
Midstate Medical Center	5.74	No
Waterbury Hospital	5.77	No
Milford Hospital	6.06	No
Middlesex Hospital	6.11	No
Greenwich Hospital	6.11	No
Norwalk Hospital	6.26	No
Manchester Hospital	6.26	No
Danbury Hospital	6.26	No
Stamford Hospital	6.3	No

Hospital	HAC Score	Payment Reduction
John Dempsey Hospital	6.74	Yes
Hospital of Central CT	6.77	Yes
Lawrence + Memorial	7.02	Yes
St. Francis Hospital	7.15	Yes
Day Kimball Hospital	7.45	Yes
Hartford Hospital	7.45	Yes
Johnson Memorial Hospital	7.55	Yes
Yale-New Haven Hospital	7.62	Yes
Windham Hospital	8.06	Yes
Bridgeport Hospital	8.13	Yes
Charlotte Hungerford	8.44	Yes
St. Mary's Hospital	8.7	Yes

Less than 1 in 3 hospitals being rewarded for value/quality

After Accounting for Penalties[1], Few Receive VBP[2] Bonuses



Hospital-Acquired Condition Reduction Program, Hospital Readmissions Reduction Program.
Value-Based Purchasing.
Pay-for-Performance.

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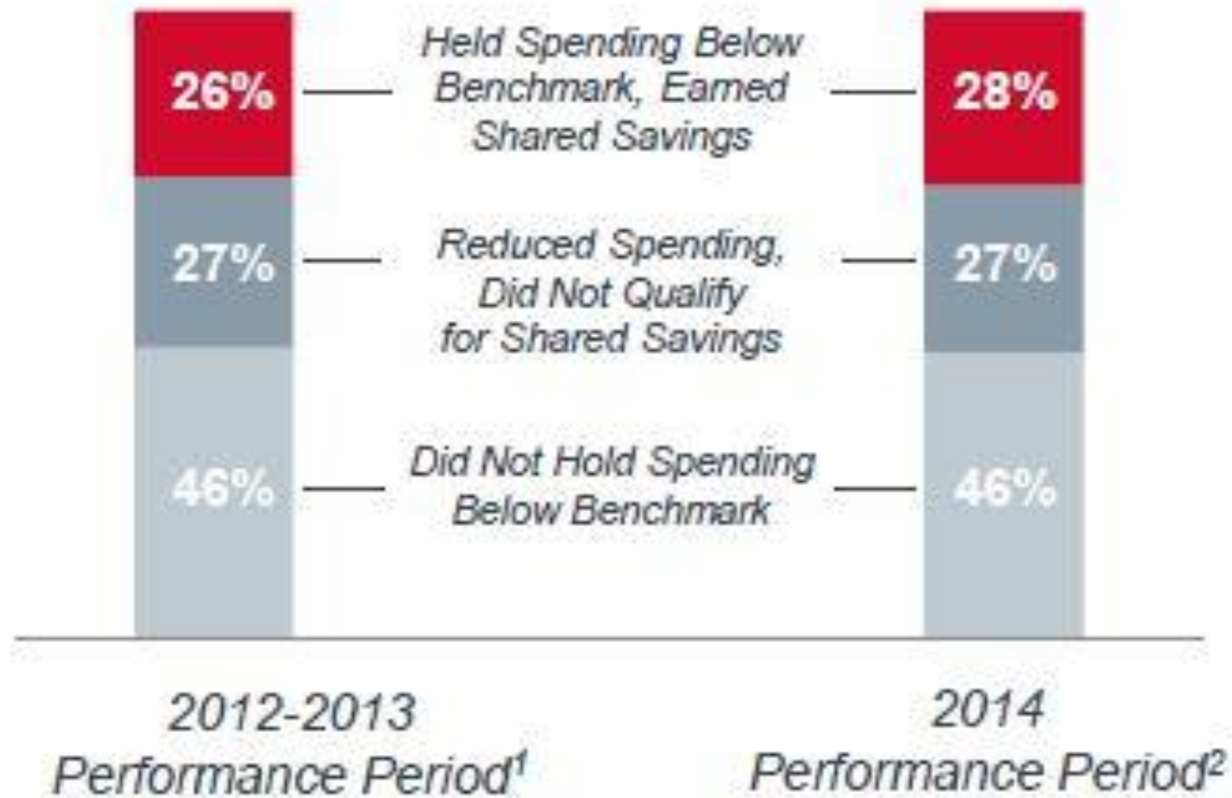
Source: Rau J, "1,700 Hospitals Win Quality Bonuses From Medicare, But Most Will Never Collect," Kaiser Health News, January 22, 2015, available at: kaiserhealthnews.org; Health Care Advisory Board interviews and analysis.

Medicare Shared Savings Program

Rewarding Lower Total Cost of Care and Increased Quality

480 ACOs in MSSP for 2017, but few generating shared savings so far

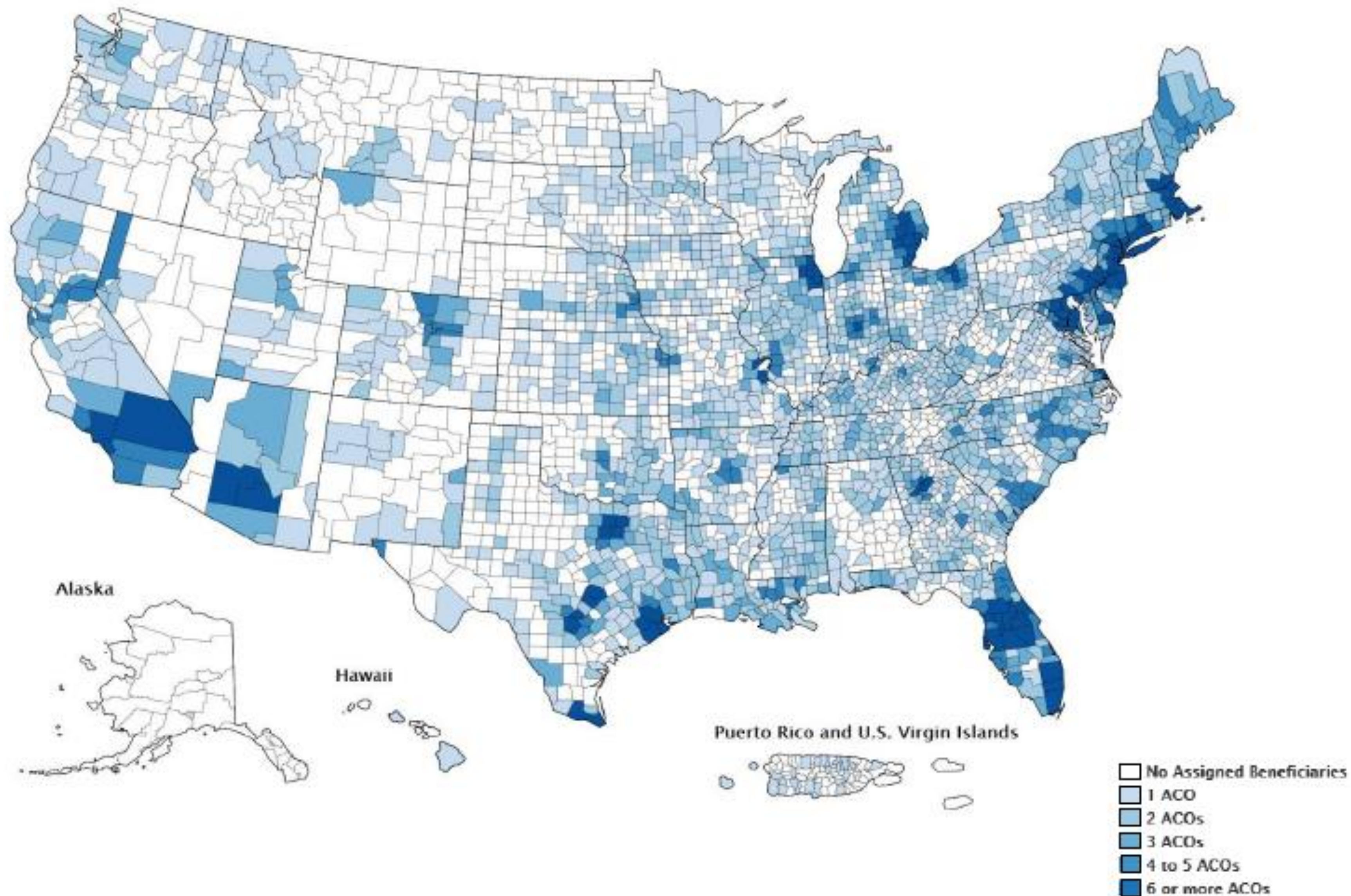


Most Providers Opting for “Up-Side Only”

	ACOs	Percent
Track 1 (one-sided)	438	91%
Track 2 (two-sided)	6	1%
Track 3 (two-sided)	36	8%

Medicare Shared Savings Program ACO Assigned Beneficiary Population by ACO by County

(counties with more than 1 percent of an ACO's assigned beneficiaries)

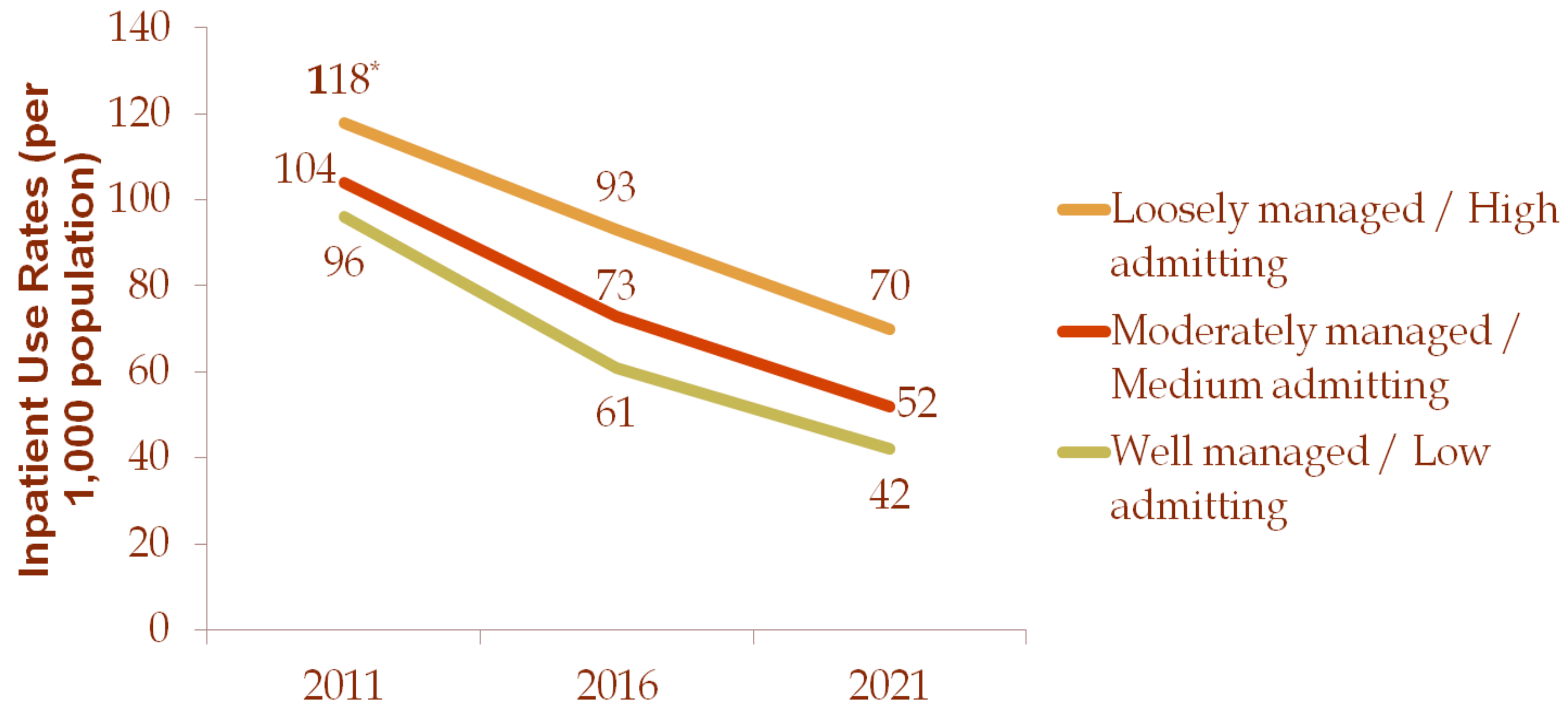


2013 Connecticut Medicare ACO Performance

ACO	States where beneficiaries reside	Type	Start date	2013 Shared Savings	2013 ACO earned shared savings
Accountable Care Clinical Services	**IA, PA, CT, MA, PA**	**Multi State**	**1/1/2013**	**$10.53 M**	**$5.16 M**
Accountable Care Coalition of Mount Kisco	NY, CT	Multi State	4/1/2013	0	0
Accountable Care Organization of New England	MA, CT	Multi State	1/1/2013	0	0
Hartford Healthcare Accountable Care Organization	CT	Single State	1/1/2013	0	0
Lahey Clinical Performance Accountable Care Org	MA, NH, CT	Multi State	1/1/2013	0	0
MPS ACO Physicians	CT	Single State	7/1/2012	0	0
Pioneer Valley Accountable Care	MA, CT	Multi State	1/1/2013	0	0
PriMed	CT	Single State	7/1/2012	0	0
ProHealth Physicians ACO	CT	Single State	1/1/2013	0	0
Saint Francis HealthCare Partners ACO	CT	Single State	1/1/2013	0	0
WESTMED Medical Group	NY, CT	Multi State	7/1/2012	0	0
Family Health ACO, LLC	CT, NY	Multi State	1/1/2014	0	0
CMG ACO, LLC	CT, NY	Multi State	1/1/2015	0	0
Northeast Medical Group ACO, LLC	CT, NY	Multi State	1/1/2015	0	0
Physicians Accountable Care Solutions, LLC	CA, MA, PA, TX, UT, WV, CT, IO	Multi State	1/1/2015	0	0
WCHN ACO	CT, NY	Multi State	1/1/2015	0	0

National Inpatient Use Rates

Milliman Projections for National Inpatient Use Rates



*2009 National Inpatient use Rate = 116

Source: Milliman, Kaiser State Health Facts, AHA

Current 2017 Aetna Commercial
Favorable Efficiency Trend in Most Categories

Efficiency Metrics - Mature Months only

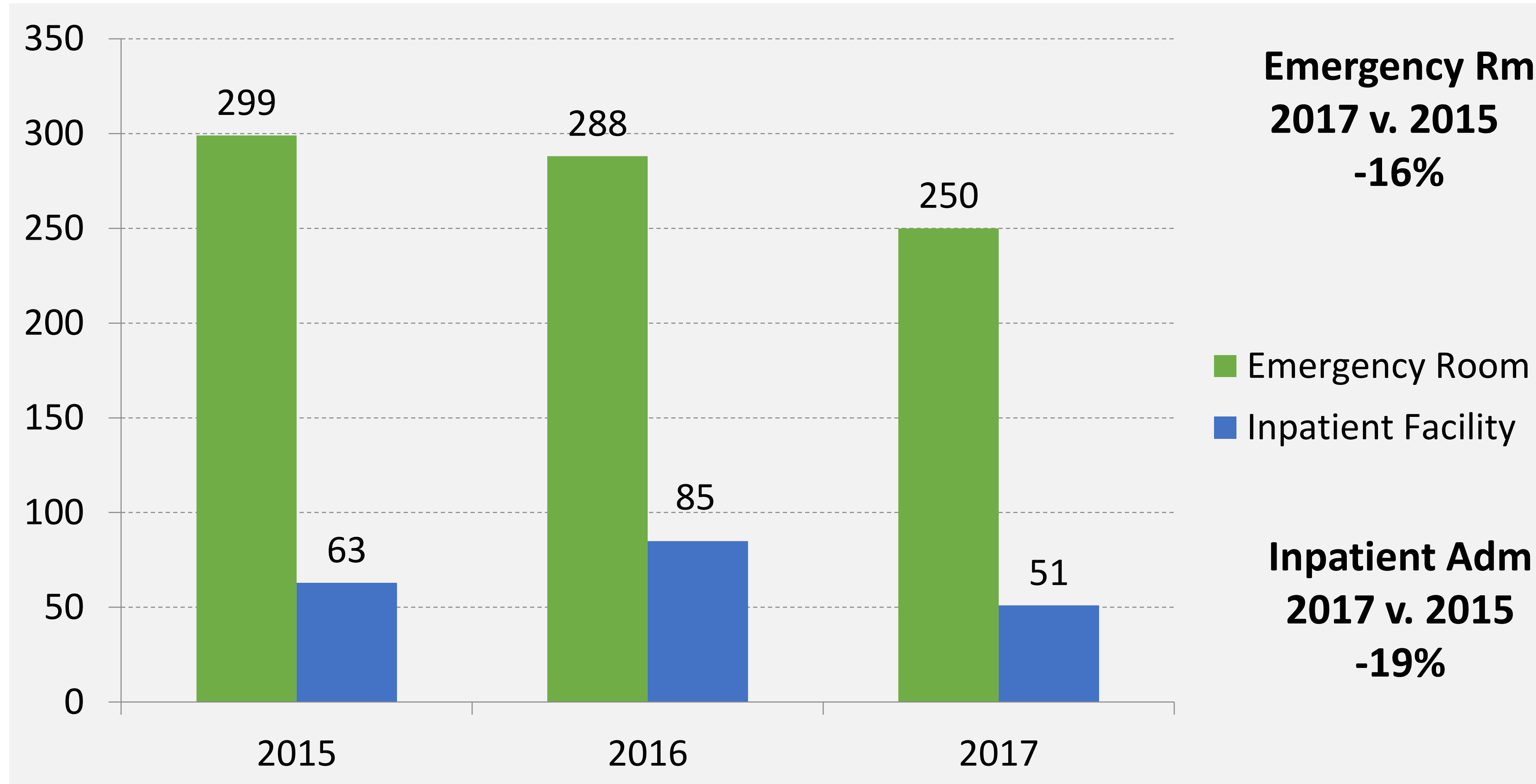
Measure Name	Actual Trend	Diffrntl vs. Target	Observations
Impactable Medical Bed Days per 1,000	-45%	-30.6	*Improvement and favorable to target*
Impactable Surgical Bed Days per 1,000	-74%	-56.8	*Improvement and favorable to target*
Impactable Medical Admits per 1,000	-45%	-12.8	*Improvement from baseline (no contracted target)*
Impactable Surgical Admits per 1,000	-47%	-11.0	*Improvement from baseline (no contracted target)*
Impactable Admits per 1,000	-46%	-23.8	*Improvement from baseline (no contracted target)*
30 Day Readmission Rate	-49%	-3.9	*Improvement and favorable to target*
Avoidable ER Visits per 1,000	-37%	-31.1	*Improvement and favorable to target*
Generic Dispensing Rate - Top 4 Drug Groups	42%	2.4	*Improvement and favorable to target*
Generic Dispensing Rate - All Drugs	12%	0.3	*Improvement and favorable to target*
High-Tech Radiology Visits per 1,000	-12%	-9.5	*Improvement and favorable to target*
CT Scans and MRIs per 1,000	-2%	12.7	*Improvement, but unfavorable to target*
Outpatient Surgery Steerage	0%	0.2	*No significant trend*
Outpatient Laboratory Steerage	6%	2.8	*Improvement from baseline (no contracted target)*
Outpatient High-Tech Radiology Steerage	-11%	-5.1	*Deterioration from baseline (no contracted target)*

Current 2017 Aetna Commercial
Favorable PMPM Trend in Most Expense Categories

PMPM Summary

Medical Cost Category	PMPM $ Diffrntl	Trends PMPM	Trends Units per 1,000	Trends Paid per Unit
Ambulatory Facility	($9.12)	-11%	-19%	16%
Capitation	$0.00			
Emergency Room	($3.83)	-14%	-22%	-2%
Home Health	($5.05)	-50%	-36%	-18%
Inpatient Facility	($69.20)	-50%	-37%	-20%
Lab	($7.77)	-26%	-16%	-12%
Medical Pharmacy	($8.59)	-26%	-44%	18%
Mental Health	($10.56)	-55%	-1%	-54%
Pharmacy	$10.00	6%	5%	1%
Primary Physician	($4.68)	-21%	-18%	-4%
Radiology	($5.12)	-12%	-17%	-4%
Specialist Physician	($15.41)	-12%	-8%	-11%
State Assessments	$0.00			
Grand Total	($135.01)	-21%		

Aetna Commercial Utilization (2017 v. 2015 – Units per 1,000)

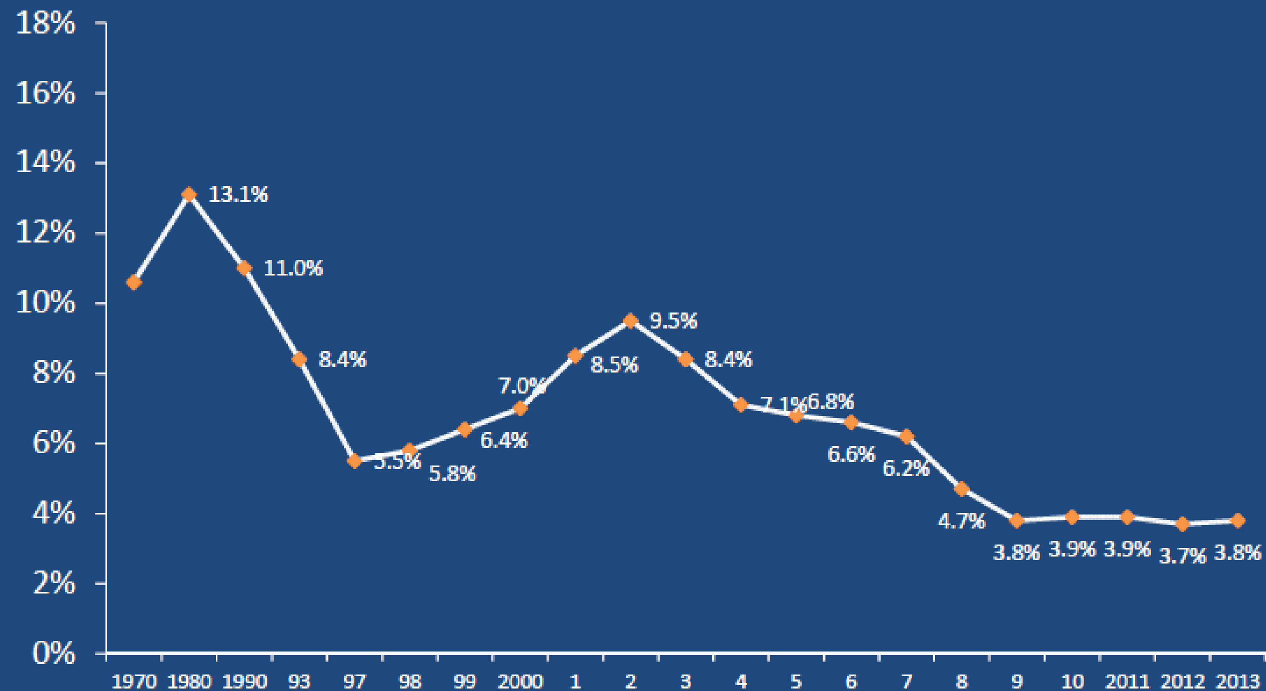


Interventions are Showing Signs of Success

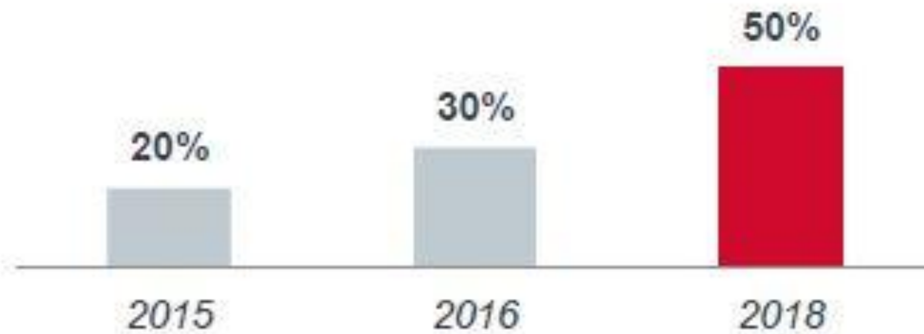
Spending growth has slowed.

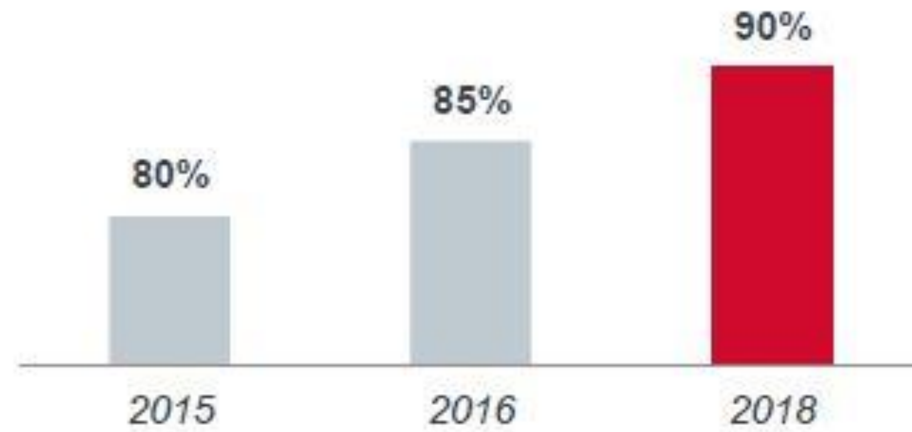
This is the lowest rate on record for any three-year period and less than one-third the long-term historical average stretching back to 1965

On a per capita basis, healthcare spending has grown at an average annual rate of 1.3% since 2010.



Medicare program leading the transformation





MACRA

Changing the Payment Model
To Make Physicians Change Agents

What is “MACRA”?

The **Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)** is a bipartisan legislation signed into law on April 16, 2015.

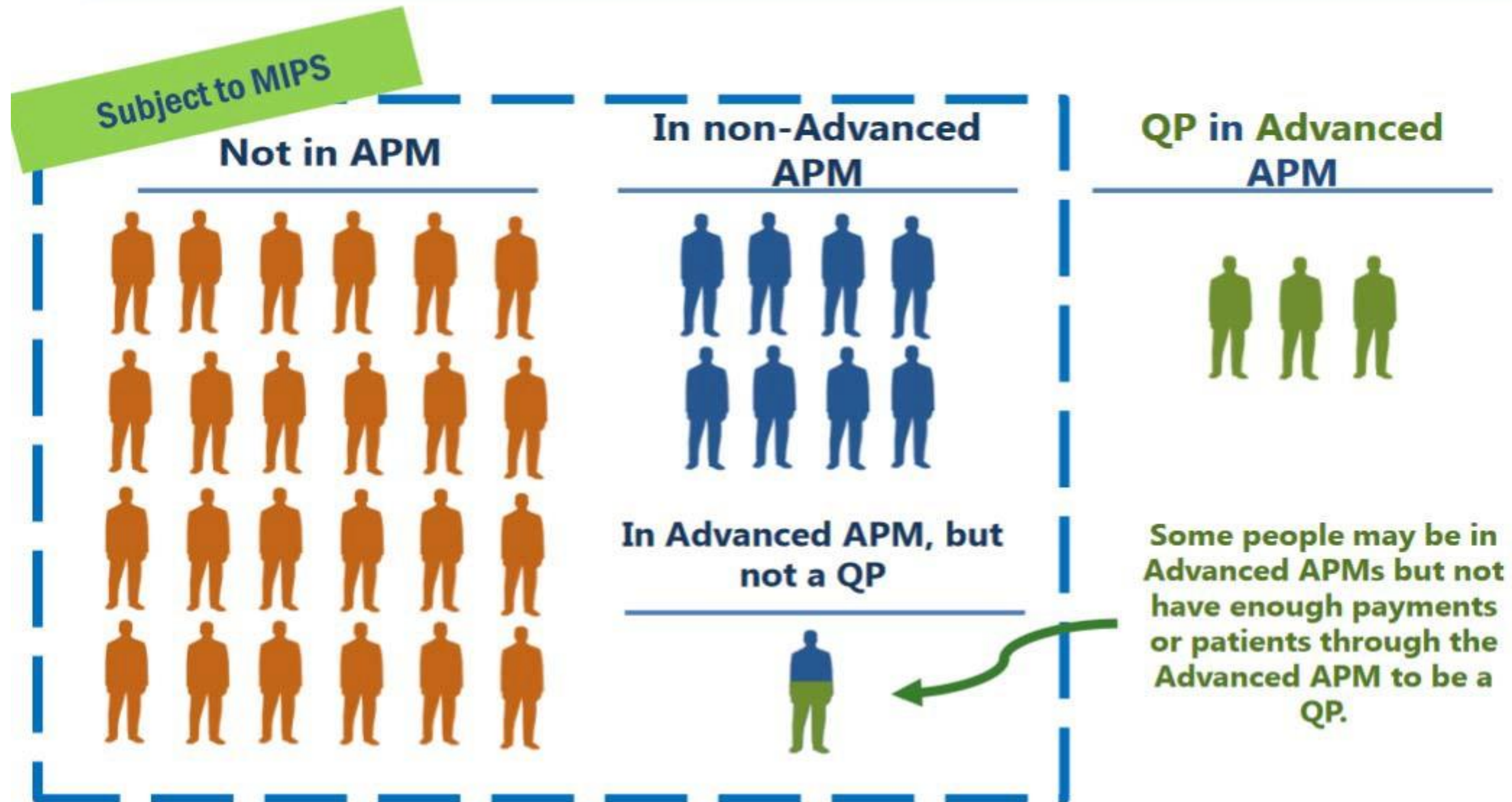
What does Title I of MACRA do?

- **Repeals** the Sustainable Growth Rate (SGR) Formula
- **Changes the way that Medicare** rewards clinicians for **value** over volume
- **Streamlines** multiple quality programs under the new **Merit-Based Incentive Payments System (MIPS)**
- Provides **bonus payments** for participation in **eligible alternative payment models (APMs)**

Quality Payment Program

The Merit-based Incentive Payment System (MIPS)	or	Advanced Alternative Payment Models (APMs)

Note: Most clinicians will be subject to MIPS.



Note: Figure not to scale.

MIPS changes how Medicare links performance to payment

There are currently multiple individual **quality and value** programs for Medicare physicians and practitioners:

Physician Quality Reporting Program **(PQRS)**

Value-Based Payment Modifier

Medicare EHR Incentive Program

MACRA streamlines those programs into **MIPS**:

Merit-Based Incentive Payment System **(MIPS)**

How will physicians and practitioners be scored under MIPS?

A single MIPS **composite performance score** will factor in performance in **4 weighted performance categories**:

Quality

Resource use

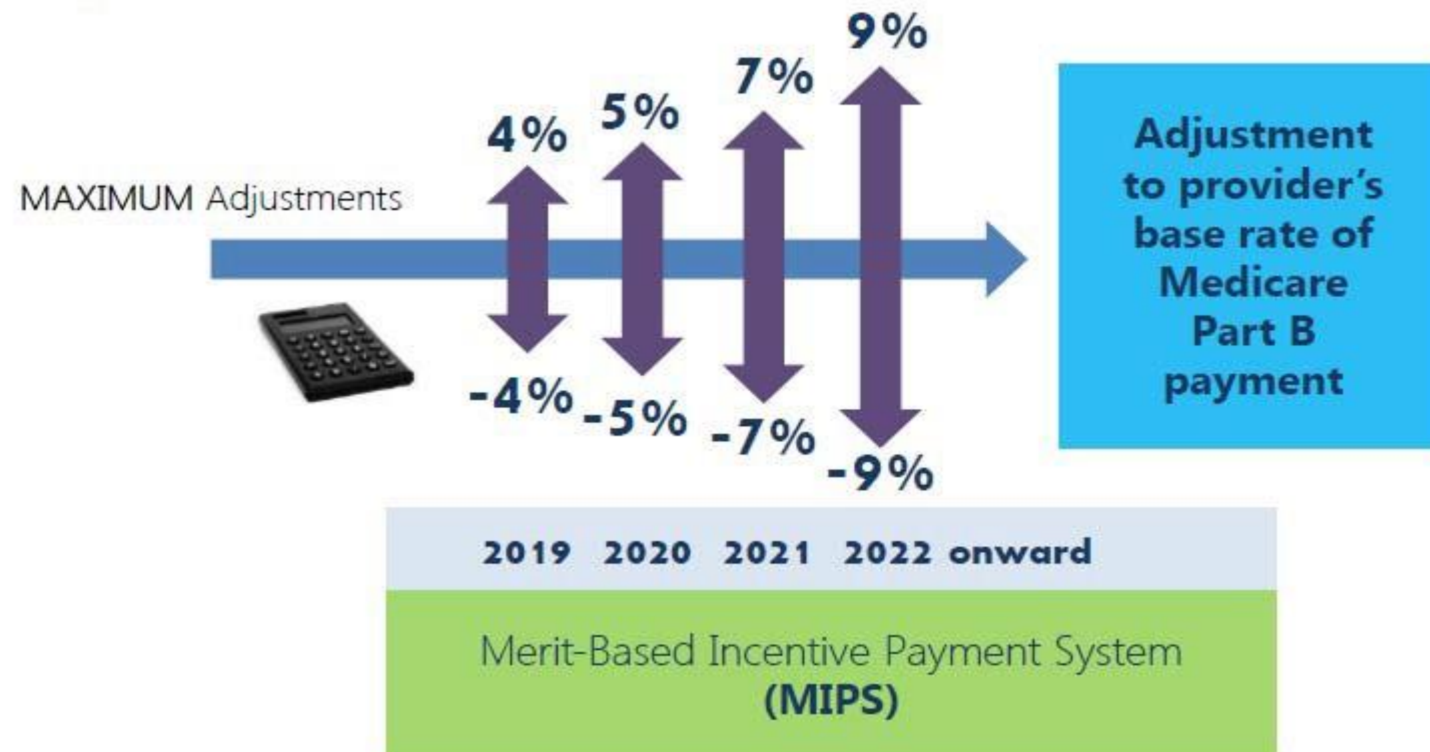
Clinical practice improvement activities

Meaningful use of certified EHR technology

MIPS Composite Performance Score

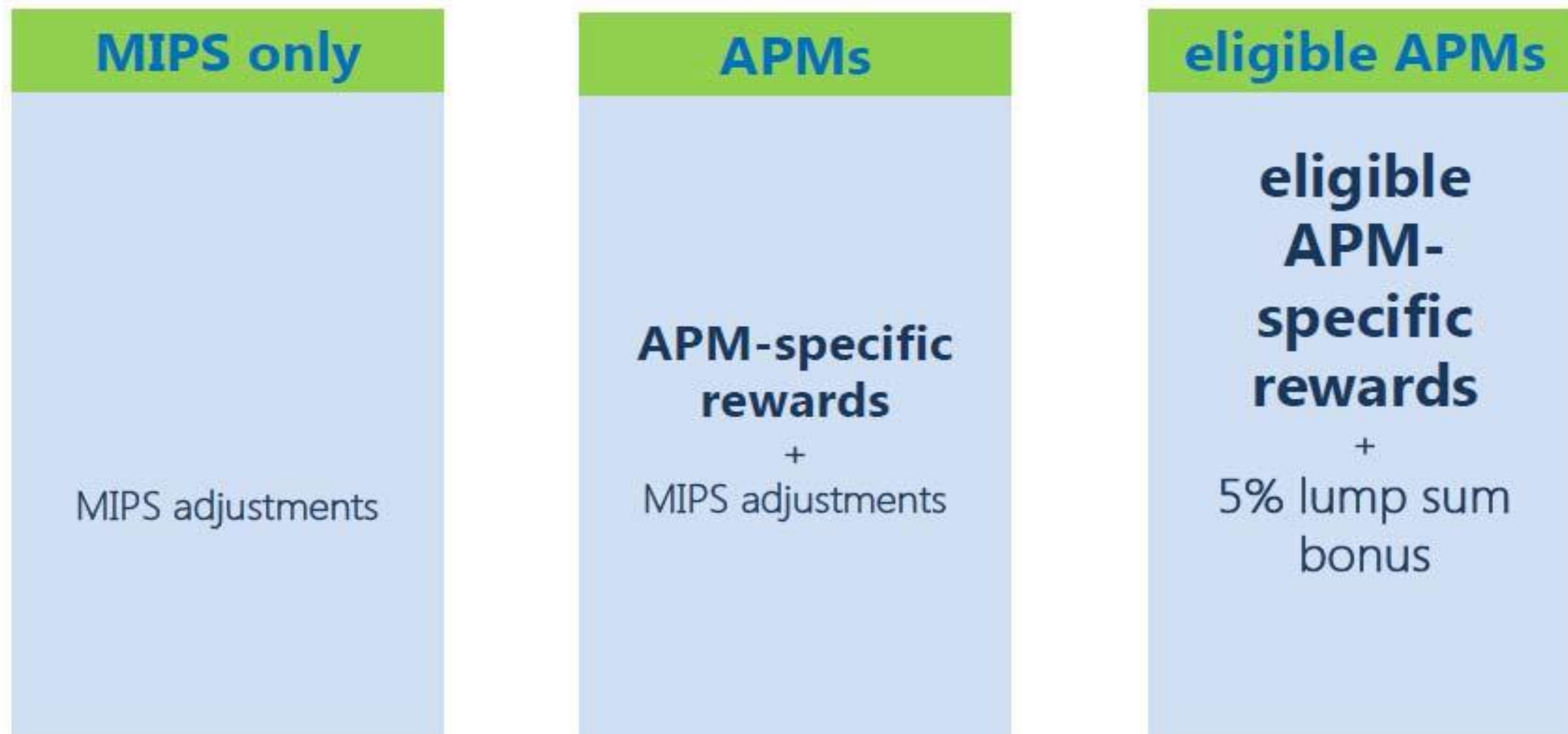
How much can MIPS adjust payments?

- Based on the MIPS **composite performance score**, physicians and practitioners will receive positive, negative, or neutral adjustments up to the percentages below.
- MIPS adjustments are **budget neutral**. A **scaling factor** may be applied to upward adjustments to make total upward and downward adjustments equal.

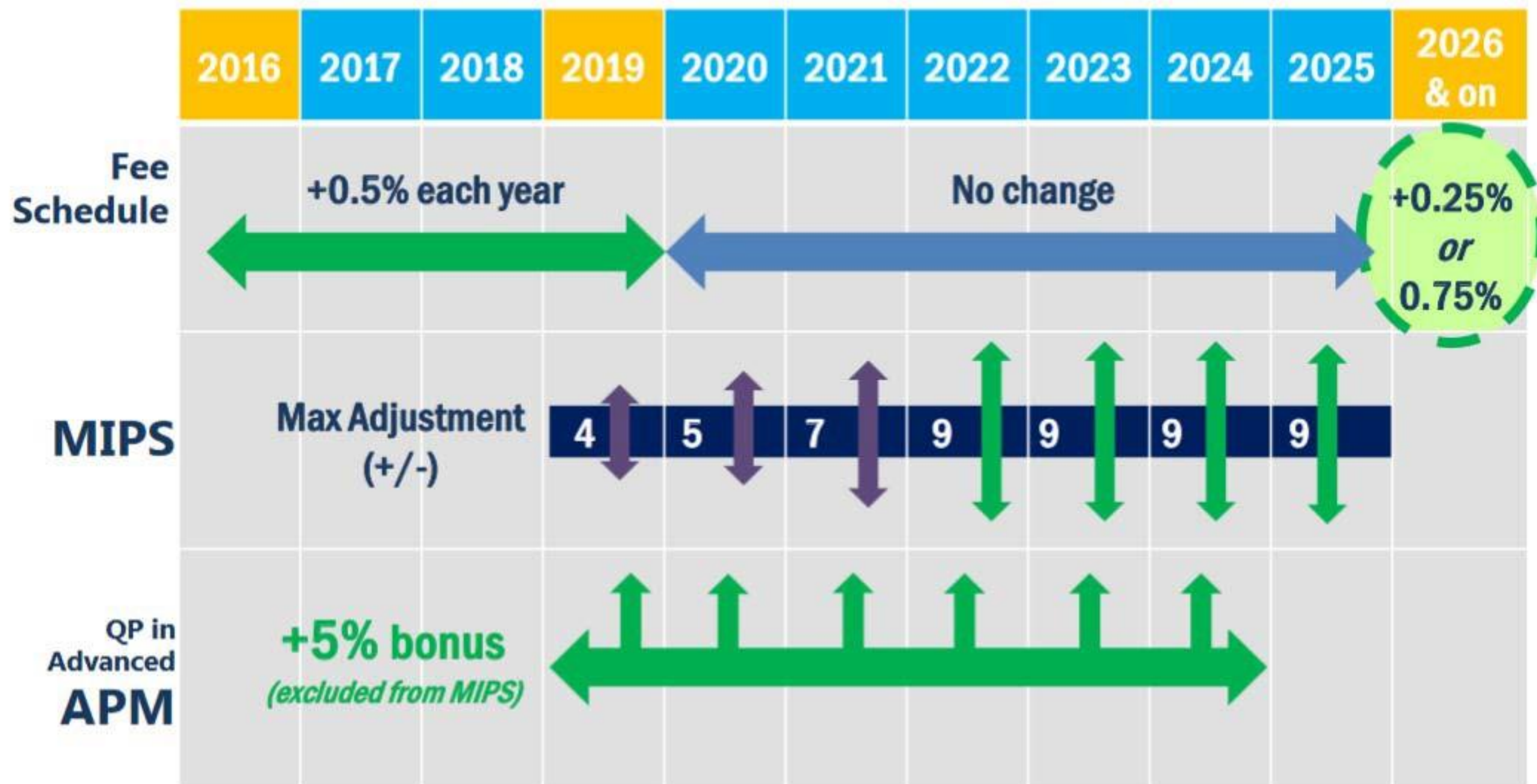


Potential value-based financial rewards

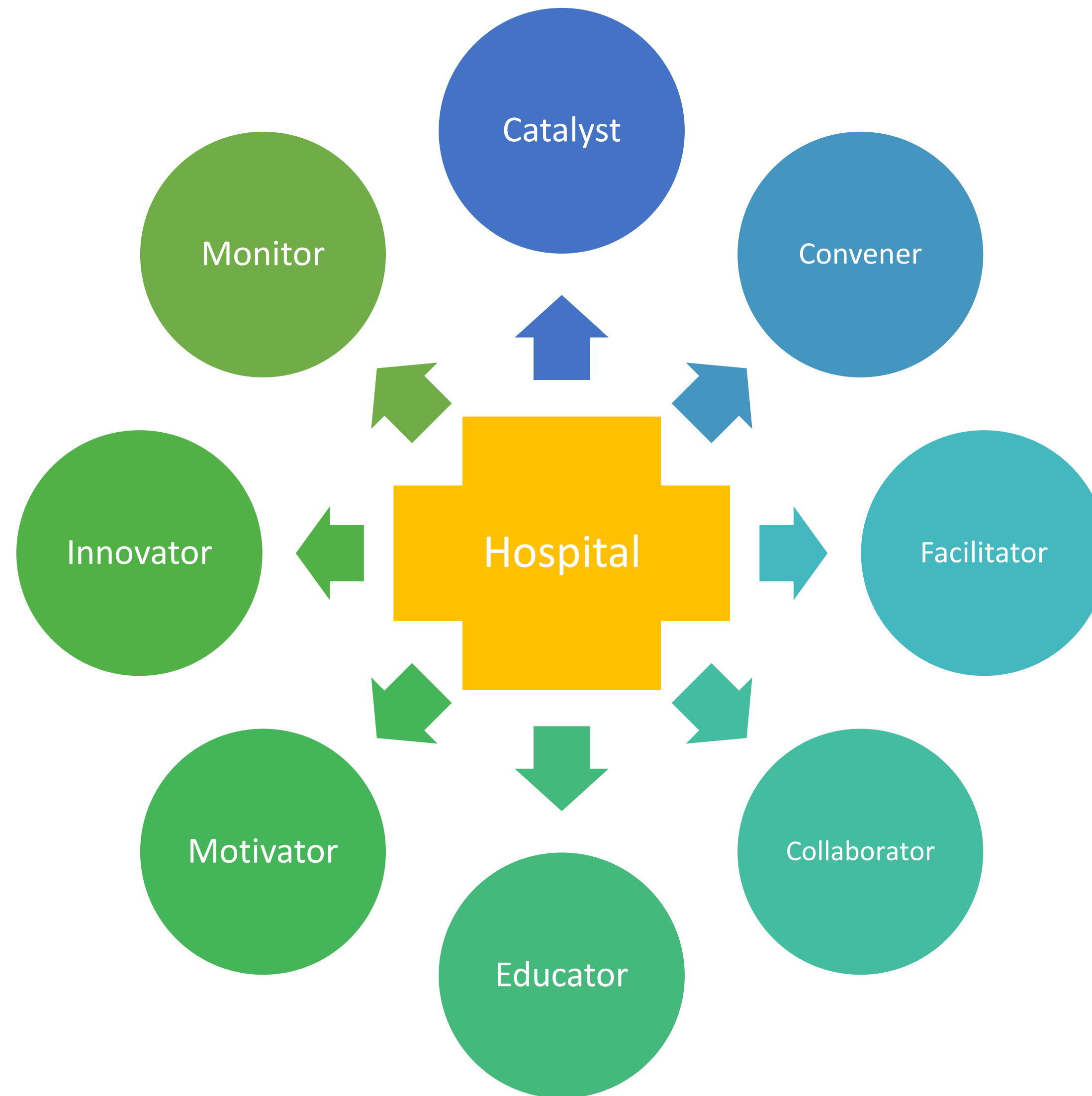
- APMs—and eligible APMs in particular—offer greater **potential risks and rewards** than MIPS.
- **In addition** to those potential rewards, MACRA provides a bonus payment to providers committed to operating under the most advanced APMs.



Putting it all together:



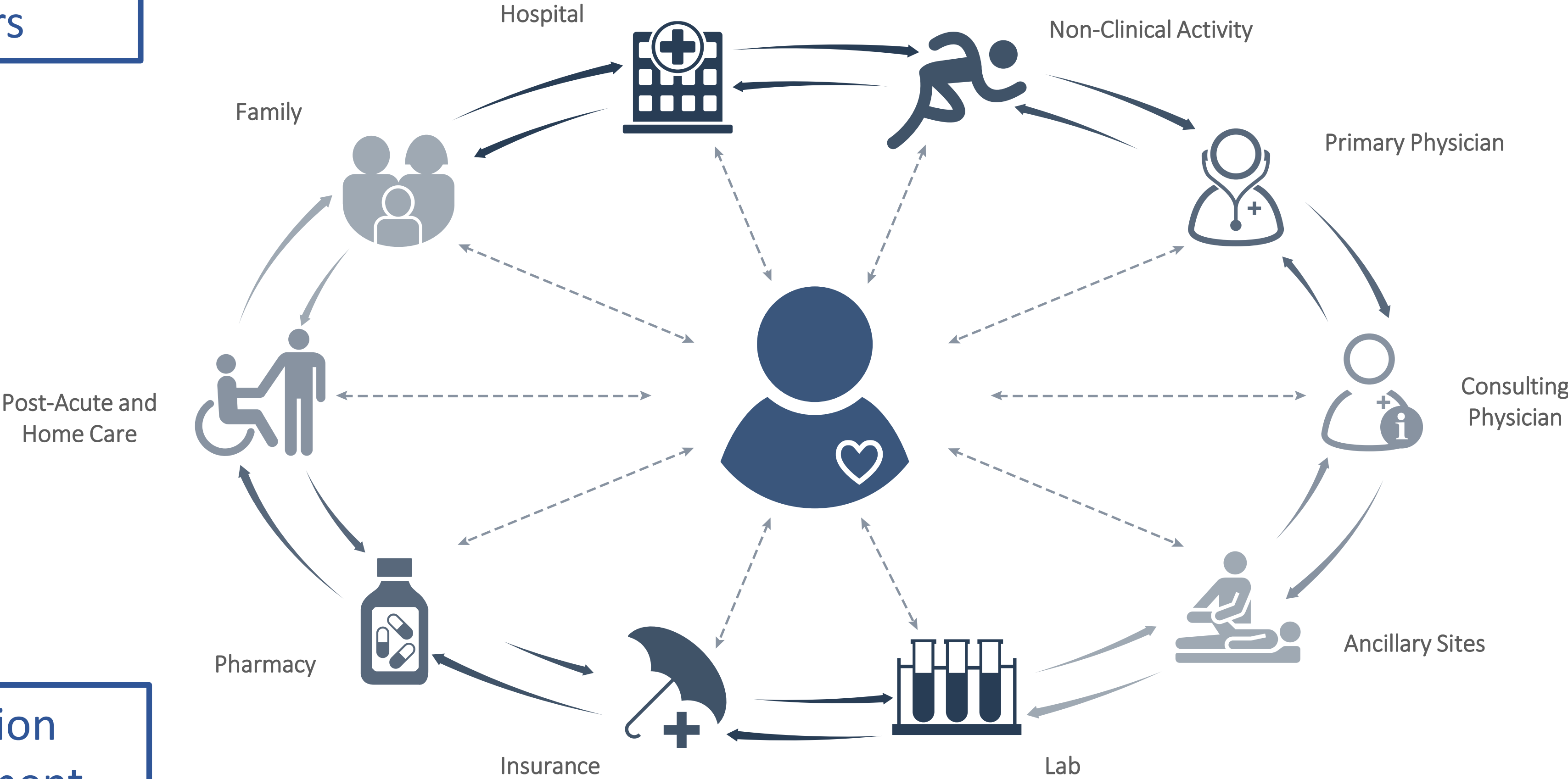
To be Effective in an Accountable Care Environment Hospitals Must Take on New Roles



Locally Integrated System of Care with the Patient at the Center

Administrative Partners

Provider Partners



Population Management Partners

Payer Partners

New Era Economic Reality

Value-Based Care

- Payment rewards population value: quality and efficiency
- Quality impacts reimbursement
- Partnerships with shared risk
- IT utilization essential for population health management
- Realigned incentives, encourage coordination

Questions?