Objectives

• Understand the environmental progression to accountable care

Using Emory Healthcare as an example to understand...

• organizational decision-making to pursue accountable care
• organizational components for accountable care
  • new payer relationships for accountable care
  • population management strategy and execution
Emory Healthcare Network

<table>
<thead>
<tr>
<th>EHN</th>
<th>Private Practice</th>
<th>TEC</th>
<th>ESA</th>
<th>Totals</th>
<th>% Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCP</td>
<td>115</td>
<td>77</td>
<td>58</td>
<td>250</td>
<td>12%</td>
</tr>
<tr>
<td>Specialists (hospital based)</td>
<td>55</td>
<td>381</td>
<td>62</td>
<td>498</td>
<td>24%</td>
</tr>
<tr>
<td>Specialists (non-hospital based)</td>
<td>288</td>
<td>949</td>
<td>41</td>
<td>1278</td>
<td>64%</td>
</tr>
<tr>
<td>Totals</td>
<td>458</td>
<td>1407</td>
<td>161</td>
<td>2026</td>
<td>100%</td>
</tr>
</tbody>
</table>

% Total: 23% 69% 8% 100%

5 Hospital Facilities
Increasing Accountability
Emory Value-Based Commercial Contracts

<table>
<thead>
<tr>
<th>Medicare Advantage*</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCBSGA 32,000</td>
</tr>
<tr>
<td>Aetna 18,000</td>
</tr>
<tr>
<td>BCBSGA 32,000</td>
</tr>
<tr>
<td>BCBSGA 38,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Payor</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017 (Projected)</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCBSGA</td>
<td>32,000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aetna</td>
<td>18,000</td>
<td>19,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cigna</td>
<td>15,000</td>
<td>15,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicare Advantage*</td>
<td>8,000</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

*Full Risk Capitation

12/11/2015
Objectives

• Understand the environmental progression to accountable care

Using Emory Healthcare as an example to understand...

• organizational decision-making to pursue accountable care
• organizational components for accountable care
• new payer relationships for accountable care
• population management strategy and execution
Setting the context...

To Err is Human
44K-98K preventable hospital deaths due to medical error

Crossing the Quality Chasm
Current system is incapable of delivering the desired level of quality & safety

“The Rand Study”
Patients only receive 55% of intended care

Costs – US & GA
17% GDP
2008 – 7% of income
2014 – 18% of Income

Stakeholder Impressions of Managed Care

Patients
- Loss of choice
- Administrative burden
- Necessary care withheld

Providers
- Administrative burden
- Financial viability

Insurers
- Predictable finances
- Necessary care withheld

Employers
- Predictable finances
- Necessary care withheld
- Dissatisfied employees
What do the stakeholders want?

**Patients**
- Choice
- Access
- Affordability

**Providers**
- Reduce admin burden
- Fair compensation

**Insurers**
- Affordable finances
- Marketable product – access, quality, and cost

**Employers**
- Affordable finances
- Satisfied employees – access, quality, and cost

Definitions

Value = \( \frac{Quality \times Experience}{Cost} \)

Cost
- Cost to deliver the care
- Cost to the purchaser

Cost
- Unit cost
- Cost of care
A Blunt Instrument... Using Payment Models to Improve Value

Questions & Comments
Healthcare Environment & Payment Models
Objectives

• Understand the environmental progression to accountable care

Using Emory Healthcare as an example to understand...
• organizational decision-making to pursue accountable care
• organizational components for accountable care
  • new payer relationships for accountable care
  • population management strategy and execution

THE CINDERELLA PARABLE - The pace of change to vary significantly by market and health system
### CMS Timeline – Alternative Payment by 2019

**2016 – 2017 Data Drive 2019 MIPS Score**

<table>
<thead>
<tr>
<th>Current System</th>
<th>Medicare and CHIP Reauthorization Act (MACRA or SGR Repeal)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Present to 2019</strong></td>
<td></td>
</tr>
<tr>
<td>Sec. Burwell – Jan ’15</td>
<td></td>
</tr>
<tr>
<td>• ’15</td>
<td></td>
</tr>
<tr>
<td>• APM – 30%</td>
<td></td>
</tr>
<tr>
<td>• 85% value-based</td>
<td></td>
</tr>
<tr>
<td>• ’18</td>
<td></td>
</tr>
<tr>
<td>• APM – 50%</td>
<td></td>
</tr>
<tr>
<td>• 90% value-based</td>
<td></td>
</tr>
<tr>
<td>• Current programs</td>
<td></td>
</tr>
<tr>
<td>• PQRS, Meaningful use, Value based modifier</td>
<td></td>
</tr>
<tr>
<td><strong>’19 to ’26 MIPS</strong></td>
<td></td>
</tr>
<tr>
<td>Payment updates</td>
<td></td>
</tr>
<tr>
<td>• ’15 – ’19: 0.5%</td>
<td></td>
</tr>
<tr>
<td>• ’20 – ’26: 0%</td>
<td></td>
</tr>
<tr>
<td>MIPS – Single Metric</td>
<td></td>
</tr>
<tr>
<td>• Quality</td>
<td></td>
</tr>
<tr>
<td>• Resource use</td>
<td></td>
</tr>
<tr>
<td>• Improvement</td>
<td></td>
</tr>
<tr>
<td>• Meaningful use</td>
<td></td>
</tr>
<tr>
<td>Max reduction</td>
<td></td>
</tr>
<tr>
<td>• 4% to 9%</td>
<td></td>
</tr>
<tr>
<td>• ’19 score based on ’16 &amp; ’17 data</td>
<td></td>
</tr>
<tr>
<td><strong>’19 to ’26 APM</strong></td>
<td></td>
</tr>
<tr>
<td>Payment updates</td>
<td></td>
</tr>
<tr>
<td>• ’15 – ’19: 0.5%</td>
<td></td>
</tr>
<tr>
<td>• ’20 – ’26: 0%</td>
<td></td>
</tr>
<tr>
<td>Bonus – 5%</td>
<td></td>
</tr>
<tr>
<td>APM</td>
<td></td>
</tr>
<tr>
<td>Minimum % of practice requirements (Medicare or total)</td>
<td></td>
</tr>
<tr>
<td><strong>After ’26</strong></td>
<td></td>
</tr>
<tr>
<td>Payment updates</td>
<td></td>
</tr>
<tr>
<td>• MIPS: 0.25%</td>
<td></td>
</tr>
<tr>
<td>• APM: 0.75%</td>
<td></td>
</tr>
<tr>
<td>MIPS maximum reduction – 9%</td>
<td></td>
</tr>
</tbody>
</table>

APM = Alternative Payment Model  
MIPS = Merit-Based Incentive Payment System
Commercial Insurance (Employer) Timeline

- Market-specific
- Employers increasingly unable to afford increasing costs
- Communication challenge
  - Viewed as any other good or service – ↓ Cost & ↑ Value
  - Difficult to measure value – so low unit cost is assumed to be high value
  - Tension between short-term financial horizon & long-term investment for value-based provider
- Impact of private and public exchanges
  - Commoditization vs. Differentiation
  - Decisions: Plan → Network → Benefits

Growth of ACO’s

| Source: The Rise and Future of Medicaid ACOs. Leavitt Partners, September 10, 2015 |
|---------------------------------|--------|
| **Medicare ACO’s**              | 424    |
| • 405 MSSP – 7.2 M Beneficiaries|        |
| • 19 Pioneer – 0.6 M Beneficiaries|  > 75   |
| **Commercial ACO’s**            | > 350  |
| – 12 to 16 M Beneficiaries      |        |
Pioneer ACO’s Improve Quality & Cost Performance Improves With Experience

<table>
<thead>
<tr>
<th>Pioneer ACO - Financial Performance (Millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
</tr>
<tr>
<td>$77</td>
</tr>
<tr>
<td>$64</td>
</tr>
<tr>
<td>($47)</td>
</tr>
</tbody>
</table>

Pioneer ACO Performance

<table>
<thead>
<tr>
<th>Year</th>
<th>Received Payment</th>
<th>Savings No Payment</th>
<th>Losses No Payment</th>
<th>Losses Paid</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>14</td>
<td>4</td>
<td>13</td>
<td>1</td>
<td>32</td>
</tr>
<tr>
<td>Year 2</td>
<td>11</td>
<td>3</td>
<td>3</td>
<td>6</td>
<td>23</td>
</tr>
<tr>
<td>Year 3</td>
<td>11</td>
<td>4</td>
<td>2</td>
<td>3</td>
<td>20</td>
</tr>
</tbody>
</table>

Total Savings: $88,000,000 in Year 1, $96,000,000 in Year 2, and $120,000,000 in Year 3
Savings per ACO: $2,700,000 in Year 1, $4,200,000 in Year 2, and $6,000,000 in Year 3
Mean Quality Score: 71.80% in Year 1, 85.20% in Year 2, and 87.20% in Year 3

Medicare Shared Savings Program

<table>
<thead>
<tr>
<th>Pioneer ACO - Financial Performance (Millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>$916</td>
</tr>
<tr>
<td>$316</td>
</tr>
<tr>
<td>($995)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year</th>
<th>Pioneer ACO Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>52</td>
</tr>
<tr>
<td>2014</td>
<td>86</td>
</tr>
<tr>
<td>Failed Quality</td>
<td>6</td>
</tr>
<tr>
<td>Savings No Payment</td>
<td>60</td>
</tr>
<tr>
<td>Losses No Payment</td>
<td>101</td>
</tr>
<tr>
<td>Losses Paid</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>220</td>
</tr>
</tbody>
</table>

Questions & Comments
Organizational Decision-Making re: Accountable Care

Objectives

• Understand the environmental progression to accountable care

  Using Emory Healthcare as an example to understand...

  • organizational decision-making to pursue accountable care
  • some key organizational components for accountable care
    • new payer relationships for accountable care
    • population management strategy and execution
Infrastructure to Support Accountable Care

• Provider Network
• Administrative Infrastructure
• Payer-Provider Partnership
• Population Management Infrastructure

Infrastructure to Support Accountable Care

• Provider Network
• Administrative Infrastructure
• Payer-Provider Partnership
• Population Management Infrastructure

• Primary Care
• Specialty Care
• Acute Care Facilities
• Ambulatory Facilities
  • Surgical
  • Imaging
• Emergency Care
• Urgent Care
• Post-Acute Care
• Other Ancillary Svcs
Infrastructure to Support Accountable Care

- Provider Network
- **Administrative Infrastructure**
- Payer-Provider Partnership
- Population Management Infrastructure
- Credentialing
- Provider Enrollment
- Provider Recruitment
- MSO Services
- Network Governance
- Board & Committee(s) Support
- Provider Relations
- Marketing
- Accounting
- Legal
- Information Services
- Compliance & Risk Management
- Actuarial Support
- Payer Contracting

Governance – Why is it important?

- Organizational credibility
  - Facilitates transparency
  - Transparency facilitates trust
- Physician engagement
  - Structured to facilitate input from many constituencies
  - Trust and broad input facilitates engagement
- Difficult decision-making
  - Success will require disruption of the status quo
  - Inclusive governance improves decision-making and facilitates execution
Governance: Emory’s Approach

Board of Managers

<table>
<thead>
<tr>
<th>Physician Class</th>
<th>Ex Officio Class</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 PCP’s &amp; 6 Specialists</td>
<td>EHC CEO, EHC CMO/CQO, TEC</td>
</tr>
<tr>
<td></td>
<td>Director, EHN President</td>
</tr>
</tbody>
</table>

Value Management Team

1 PCP & 1 Spec from each LHN

Participation Committee

1 PCP & 1 Spec from each LHN

Hospital CMO’s

Emory LHN
Emory Midtown LHN
Emory Saint Joseph’s LHN
Emory Johns Creek LHN
Southern Regional Medical Center LHN
LaGrange LHN

Board of Managers – Official decision-making body

Sample of Activities

- Oversees & approves actions of the participation committee
- Oversees and approves actions of the value management team
- Key strategic decisions
  - Required EMR as condition of participation & limited EMR vendor choices
  - Required attendance at Quality Management Forum to qualify for shared savings
Participation Committee
Value Management Team

**Value Management Team**
- Oversees all value-related programs
- Oversees individual and network performance
- Makes recommendations to the participation committee re: performance issues

**Participation Committee**
- Recommended participation criteria to the Board
- Reviews and approves all nominations & participants to the network
- Makes recommendations to the Board concerning membership termination

Local Healthcare Networks (LHN’s)

- Six voting members
- Responsible for clinical oversight of activities in their LHN
- Elected by local healthcare community
- Vehicle to receive and disseminate information
- Gives feedback to the Participation Committee concerning local nominees

Local Election for 6 MD members - 50:50::PCP:Specialist & Employed:Private reflects mix of local community
Non-voting: Hospital CEO, CNO, CQO
Recruitment & Provider Relations

What is your hook?
What makes your network attractive to independent providers?

- Safety in numbers in times of uncertainty
- Competitive rates
- Access to expensive infrastructure
  - IT
  - Population management
- Preservation of referral stream
- CMS penalty avoidance

Contracting

Contracting Goals
- “Fair share” of savings
- Incentive vs. risk-sharing
  - Incentive contracts – P4P, bundles, & shared savings
  - Risk-sharing contracts – Capitation
- Factors to be balanced
  - Infrastructure cost
  - Incentives
  - Investment for future performance – based on your strategy
### Objectives

- Understand the environmental progression to accountable care

**Using Emory Healthcare as an example to understand...**
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### Infrastructure to Support Accountable Care

<table>
<thead>
<tr>
<th>Category</th>
<th>Components</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Network</td>
<td>• Claims Payments</td>
</tr>
<tr>
<td>Administrative Infrastructure</td>
<td>• Clinical Data</td>
</tr>
<tr>
<td>Payer-Provider Partnership</td>
<td>• Labs</td>
</tr>
<tr>
<td>Population Management Infrastructure</td>
<td>• Pharmacy</td>
</tr>
<tr>
<td></td>
<td>• Attribution Model</td>
</tr>
<tr>
<td></td>
<td>• Utilization Management</td>
</tr>
<tr>
<td></td>
<td>• Provider Relations</td>
</tr>
<tr>
<td></td>
<td>• Non-EHN Provider Contracts</td>
</tr>
<tr>
<td></td>
<td>• Insurance Relations</td>
</tr>
<tr>
<td></td>
<td>• Insurance Risk-Bearing Partner</td>
</tr>
<tr>
<td></td>
<td>• Benefit Design</td>
</tr>
<tr>
<td></td>
<td>• Employer &amp; Broker Relations</td>
</tr>
<tr>
<td></td>
<td>• Underwriting</td>
</tr>
<tr>
<td></td>
<td>• Sales &amp; Distribution</td>
</tr>
</tbody>
</table>
Who manages the risk?

**Mitigating Medical Management Risk**
- High risk patient management
- Thoughtful use of resources
- Reliable care processes

**Mitigating Insurance Risk**
- Law of large numbers – Membership
- Financial reserves

The Ideal Payer Partner

- Insurance risk
  - Financial reserves
  - Provisions for outliers
  - Administrative support
    - Underwriting
    - Claims processing
  - Non-comprehensive network
    - Provider contracting
    - Coordinate payer resources
    - Marketing & sales

- Data & analytics
  - Timely & accurate data flow
  - Analytics support
  - Contract logistics
    - Attribution
    - Benefit design
    - Attribution
Questions & Comments
Administrative Infrastructure & Payer Partner Characteristics

Objectives

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Infrastructure to Support Accountable Care

- Provider Network
- Administrative Infrastructure
- Payer-Provider Partnership
- Population Management Infrastructure

- Clinical Pathways
- Risk
  - Stratification
  - Optimization
- Care Coordination
- Allied providers
- EMR & Practice Mgmt System
- Electronic Connectivity

- Analytics & Workflow Support
  - Clinical
  - Financial
- Patient Engagement Tools
- Performance Measurement
- Quality Improvement

Population Stratification

- Hi Risk 5%
- Rising-Risk 20%
- At-Risk 40%
- Healthy Patients 35%

Care Coordination

Care Plan Execution

Patient Engagement

Advisory Board Patient Risk Paradigm
Population Management

↑ Intended Care & ↓ Unintended Care

- Avoidable Utilization
  - Avoidable ED visits
  - Avoidable hospitalizations
  - Other avoidable services
  - Avoidable harm

- Care Plan Execution
  - Gaps in care

- Intended Care
  - Inefficient care

Population Management

Care Coordination

- Avoidable Utilization
  - Avoidable ED visits
  - Avoidable hospitalizations
  - Other avoidable services
  - Avoidable harm

- Care Plan Execution
  - Gaps in care

- Intended Care
  - Inefficient care

Care Coordination Program

- Analytics
  - Data aggregation
- Care coordinator program
  - Patient risk stratification
  - Outreach to highest risk (3.5%)
- Patient-centered primary care
  - Team-based outreach
  - Outreach to “lower” high risk
Impact of Care Coordinator Outreach

1,800 patient cohort: Approximate reduction of 15 ED visits/month and 7 hospitalizations/month for entire cohort

Population Management Analytics and Work Flow Redesign

- Disease registry
  - Identify registry candidates
  - Identify missing care elements
- Team-based work flow redesign
  - Visit-based standard work
  - Proactive outreach
Analytics & Decision-Support Platform

Data & Analytics Challenges
- Disparate data sources
- Non-analyzable data sources (paper, non-discrete electronic data)
- Data acquisition, normalization, & transformation
- Data presentation: Accessible, understandable, & timely

Emory Solutions
- Financial analytics platform (based on paid claims)
  - Financial measurement & limited clinical measurement
- Disease registry platform – Point of care and population-level analytics
- Care coordination platform – Stratification & work-flow support
Develop Population Management Capabilities

NCQA Level III
Patient Centered Medical Home Recognition

- Training Program
- Cohorts of 8-10 practices per trainer

✓ WORKING AS A TEAM
  Coordinate care with all working at the top of their license

✓ USING DATA
  How to use cost & quality data to achieve practice & network success

✓ MANAGING CARE FOR POPULATIONS
  Prospectively managing patients with chronic conditions

✓ ENGAGING PATIENTS
  Skills to empower patient self-management

✓ COORDINATING CARE WITH THE MEDICAL NEIGHBORHOOD
  Facilitate high functioning relationships with specialists

✓ IMPROVING QUALITY
  Learn quality improvement techniques

✓ PRODUCING EVIDENCE FOR NCQA RECOGNITION
  Assist in creation of documentation for NCQA recognition

---

Population Management
Episode-Specific Redesign

 Efficient Care
 Avoidable harm
 Reliable Care
 Intended Care
 Inefficient care

**Episode-Specific Redesign**
- Analytics
  - Identify unnecessary variation
- Multidisciplinary team redesign
  - Eliminate unnecessary variation
- Develop new “care plan”
- Execution & sustainability
  - Decision support
  - Measurement and feedback
Episode-Specific Redesign – Cardiology

Door to Balloon Time
Rate of meeting 90-minute FMC2B goal in EMS-transported STEMI patients
- Begun participating in ECG
- Added ED Staff
- Dedicated STEMI program

Bivalirudin Use
- Encouraged ED physicians to use bivalirudin
- Increased use of bivalirudin to over 50%

Remote Artery Access
- Rate of radial access during PCI (Sept 2013 through Nov 2014)
- All physicians with ≥ 10 procedures

Episode-Specific Redesign – Colorectal Surgery

Colorectal Value Report for Surgery

HospiSAR Colorectal SSI trend at EUH in Colorectal Surgery

NSQIP SAR’s 2010-2014

Anastomosis Prevention Process

NSQIP

30-day SSI

Accomplished:
- Improved Patient Education
- ImprovedSurgical Preparation
- ImprovedSurgeon Communication
Questions & Comments
Population Management Infrastructure

System Transformation
Emory Healthcare Network Advantage
Emory Healthcare Network Advantage
In collaboration with CareMore™

Risk Stratification
- Medicare Advantage Enrollees
- Healthy Start Visit
- Hospitalization
- Prospective Risk Analytics
- PCP Referral

Life Happens
- Unstable High Risk
- High Risk
- Rising Risk
- Moderate Risk
- Rising Risk
- Low Risk

Risk Stabilization
- Extensivist Care Ctr
- Care Ctr
- Care Ctr PCP
- PCP Care Ctr
- PCP Care Ctr
- PCP

Outcomes
- Readm 10% v. 18%
- Avg HbA1c 7.08%
- 57% fewer amputations
- Fewer Bed Days Hosp – 63%
  SNF – 67%

Emory Healthcare Network Advantage
In collaboration with CareMore™

Coordinated Care Centers
- Staff
  - Extensivists
  - Advanced Practice Providers
  - Nurse Coordinators (RN)
    - Care Coordinators (MA)
    - Administrative Staff
- 30 clinical programs (e.g. diabetes, CKD, wound, ...
The PCP’s Sidekick

**Advantage**

<table>
<thead>
<tr>
<th>Improved Patient Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCP</td>
</tr>
<tr>
<td>Extensivist</td>
</tr>
</tbody>
</table>

**Clinical Programs**
- Executed by Care Center APPs
- Evidence-based protocols
- 30 clinical program
  - Diabetes, CKD, Wound...

**Care Coordination Team**
- Nurse coordinator (RN)
- Care coordinator (MA)

**Support to Clinical Team**
- Specialists, Skilled Nursing Facilities, Hospitals
- Referrals, prior auth., etc.

Questions & Comments

The Emory Healthcare Network