Physician Leadership Imperatives in Clinically Integrated Organizations

CIO and ACO Models

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Presentation Overview

1) Redistribution of Revenue by Payer Category

2) Drivers and Challenges in Health Care Today
   - Macro Environmental Impetus to Value Based Care

3) Governance/Management/Operational Structures for CIOs & ACOs
   The "Optimal" Clinical Model

4) Medicare Shared Saving Program – A Snapshot

5) Conclusions and Enterprise Imperatives

6) Appendix
   - Building an ACO Medicare Shared Savings Program (MSSP)
   - Core Governmental/Commercial Payer Strategies for CIOs/ACOs
   - AMGA "High-Performing" Health System

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Redistribution of Revenue by Payer Category

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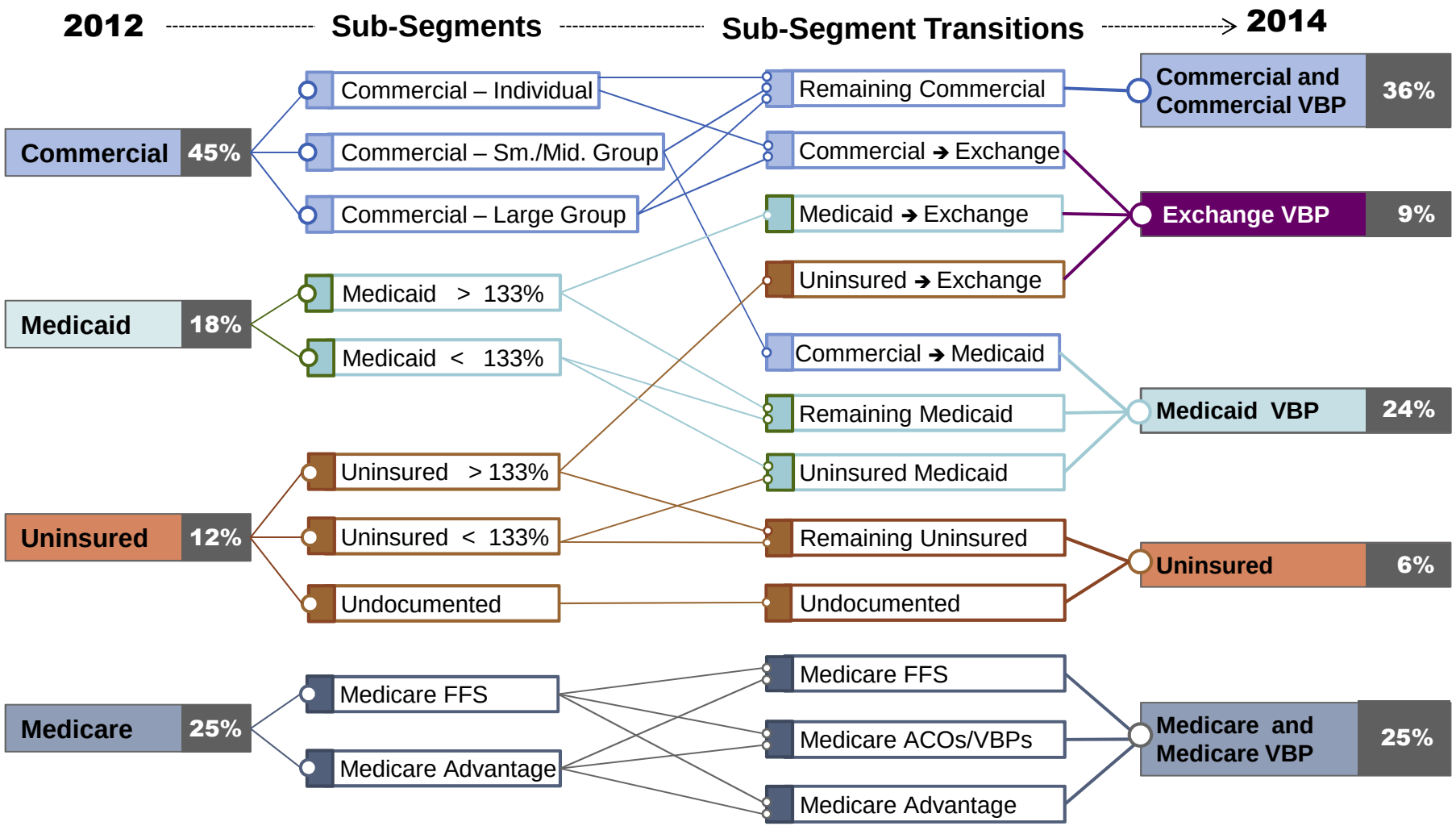
PROPRIETARY AND CONFIDENTIAL

Redistribution of Revenue by Payer Product Category*

– Southwestern Health System Payer Mix – Commercial Example

ACA "ROLLOUT"



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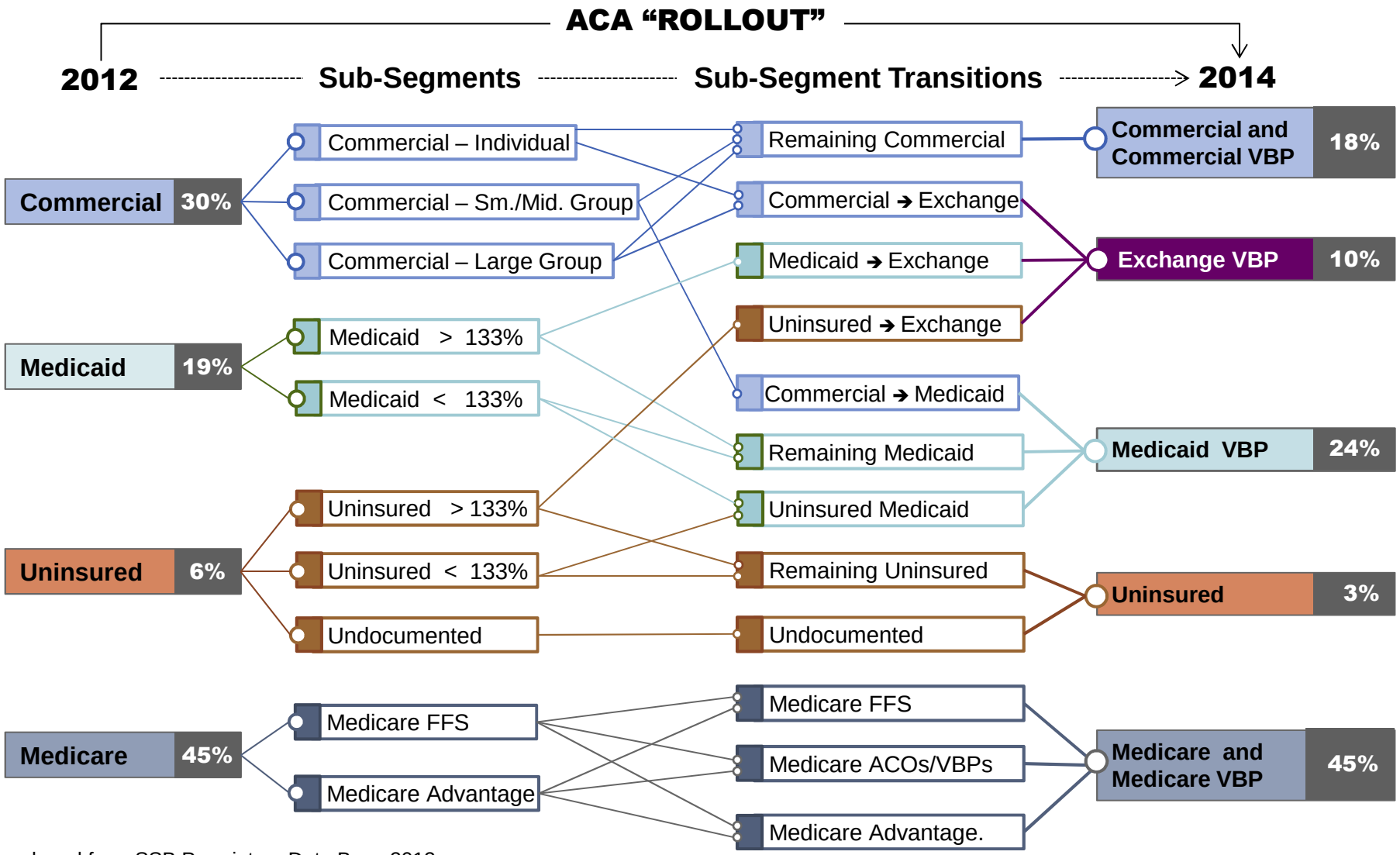
Redistribution of Revenue by Payer Product Category*
– Northeastern Health System Payer Mix – Medicare Example



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Drivers and Challenges in Health Care Today

Macro Environmental Impetus Towards Value Based Care

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Navigating the Perfect Storm

- Too much cost
- Too many patients
- Too little funding
- Too few professionals

Past and Current Governmental Impacts

Balanced Budget Act (1997)
Sustainable Growth Rate (SGR) established, now a $300+ billion underfunded liability related to physician reimbursement rates

Medicare Modernization Act (2003)
Medicare Part D Prescription Drug Benefit
Transition to MS-DRGs

Deficit Reduction Act (2005)
Decreased reimbursement for office-based ancillaries starting January 2007

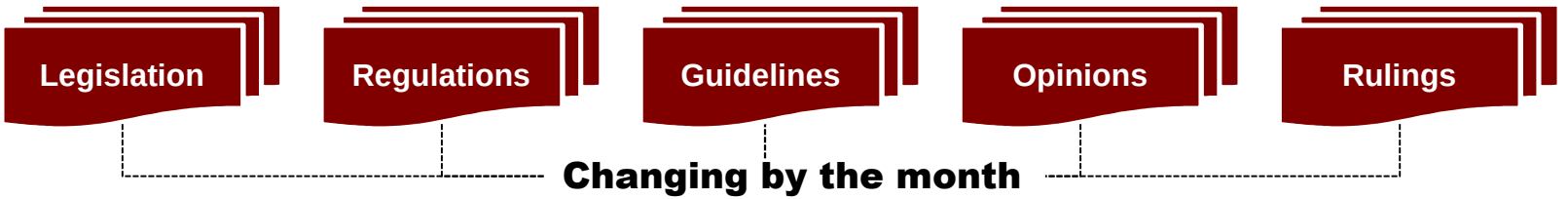
Tax Relief and Health Care Act (2006)
Medicare Medical Home Project begins in up to eight states in 2009

Patient Protection and Affordable Care Act (2010) – Multiple elements phasing in from 2010-2019 with significant, across-the-board impacts on health plans, hospitals and physicians

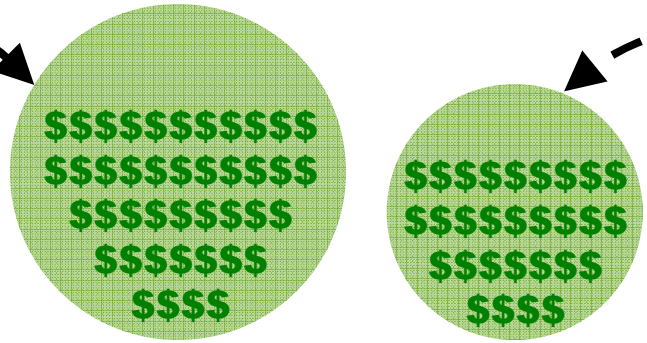
- **Supreme Court Decision – 6/28/12 @ 10:10 am EST**
  5-4 Vote lead by Chief Justice Roberts-ACA is Constitutional; Individual Mandate is a tax; Medicaid Mandate is limited and Severability is not an issue
- **Insurance Exchanges Go Live 2014**
  16-32 million Americans will enter state based insurance exchanges and expanded Medicaid programs with virtually all reimbursement structures migrating to Value-Based methodology

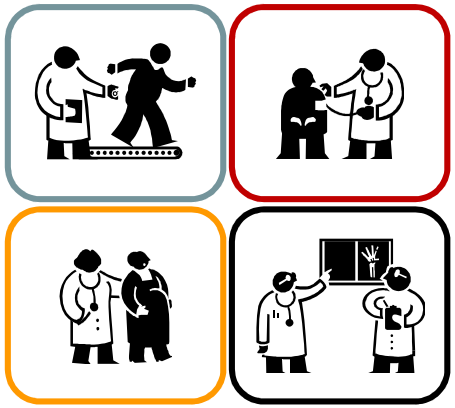
BOTTOM LINE

Profound changes ahead for all health care organizations



FFS Is Evolving to Value-Based Reimbursement
– CIO/ACO Structure Facilitates FTC Compliant Clinical Integration





CURRENT SYSTEM

Fee-for-Service (1-3 Revenue Streams to Providers)

- **Reward volume over value of services**
- **Less than optimal distinction of differences in quality of care even with typical performance metrics**
- Spotlight inequities in access
- Limit physician/patient face time to deal with complex or challenging conditions
- Discourage coordination of care over time and across the continuum of care
- Undermine strong physician/patient relationships and team-based care

Provider Community

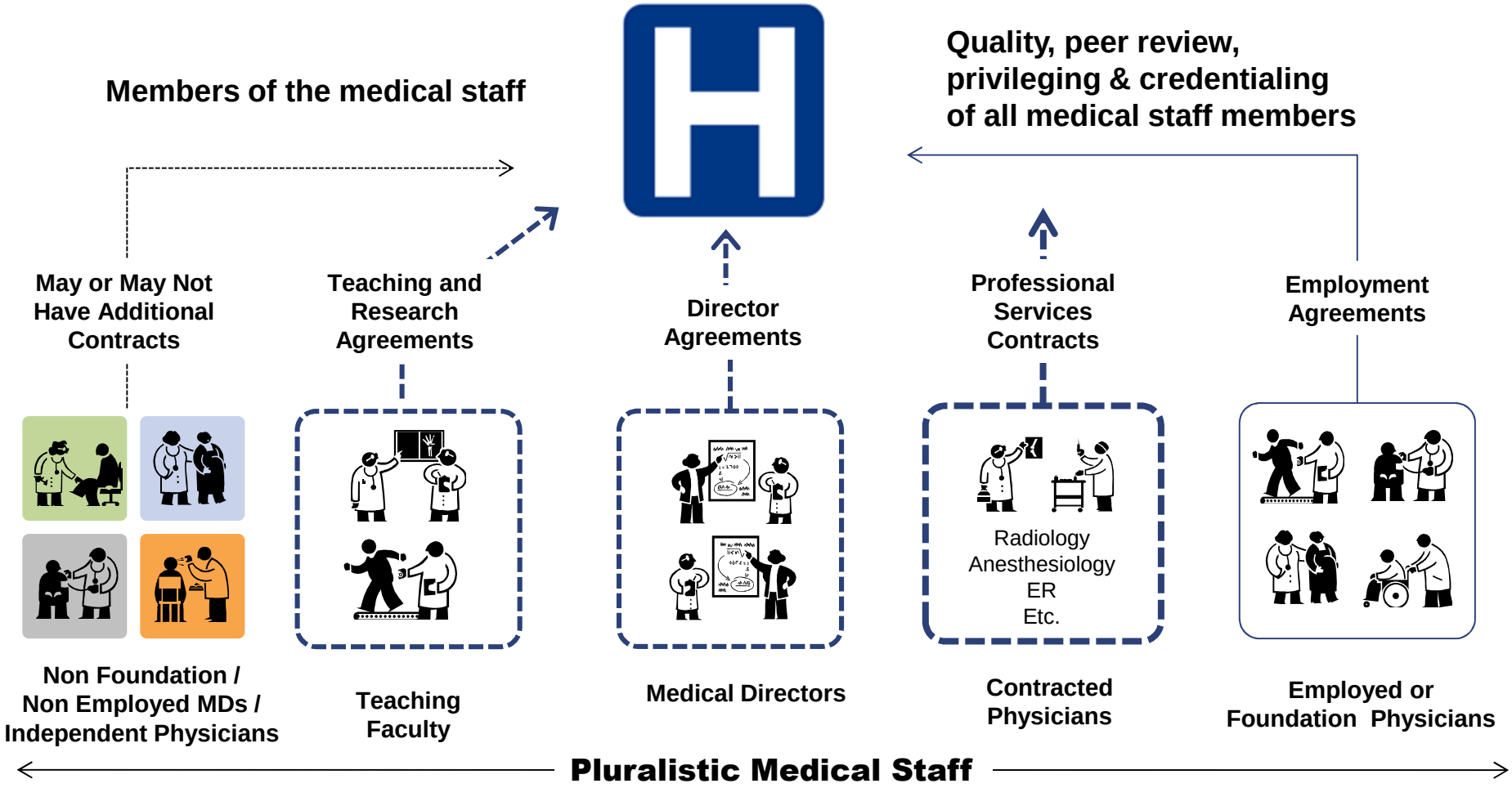
REFORMS TO REDUCE COSTS

Value-Based Payment (5-7 Revenue Streams to MCI Providers)

- **Clinically Integrated Organizations positioned to optimize reimbursement changes and quality requirements**
- **CIO Structure is just not just a new PHO (e.g., contracting entity). Real "Clinical Glue" is necessary for Value –Based Payment to stand up to FTC review**
- Pay for "Care Management"
- Pay based on evidence-based care
- Payments tied to measurable standards clear to providers and consumers
- Mobility of Care - Taking the right care to right place as well as optimizing existing bricks and mortar

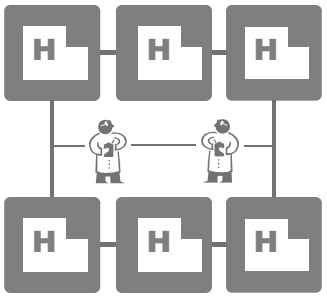
FTC Compliant Clinical Integration

– Optimizing the Continuum of MD Medical Staff Relationships Especially for Non-Economically Integrated Physicians (e.g., The Independent Medical Staff)



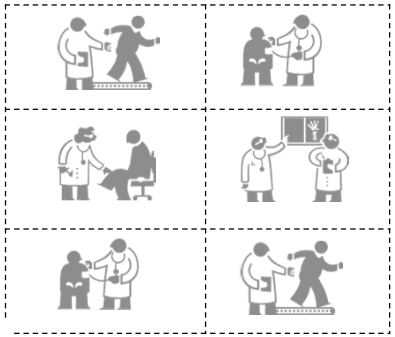
FTC Compliant Clinical Integration / Structural Overview
– The Four Organizational Parameters for FTC Approval

Hospitals and Employed Physicians



MCI Structure Defined by Agreements

Independent Physicians



Organizational Parameters

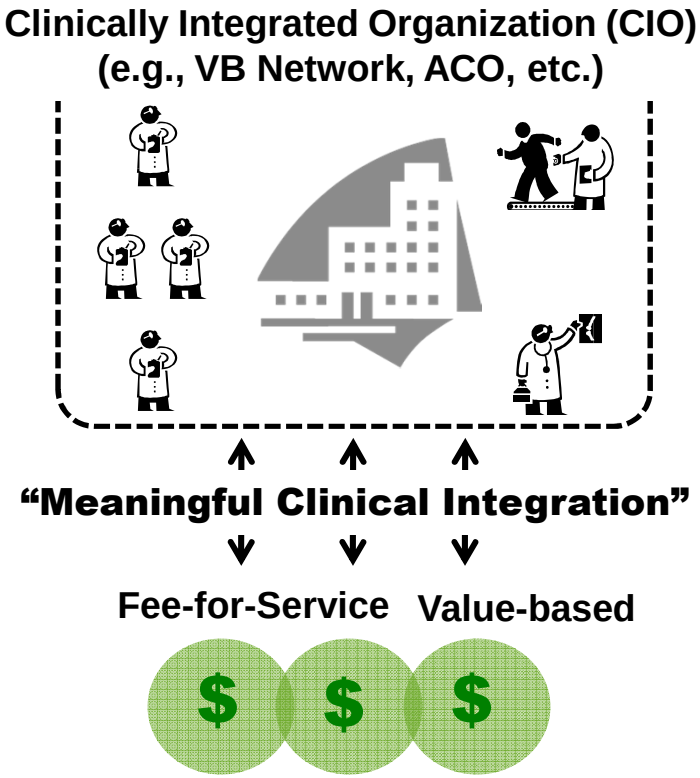
1) Clinical Scope	2) Membership	3) Performance Improvement	4) Capital Requirements
Encompasses full continuum of care (inpatient, outpatient, alternative care, and collaborative care settings)	Targeted at physicians whose participation has potential to maximize quality and efficient resource utilization	Designed to improve quality and reduce costs through protocols adherence supported by comprehensive data collection and reporting	Significant investment required to develop and deploy technology infrastructure (clinical and financial) to support improved care delivery

Joint negotiation

Payers

Base Reimbursement
Shared Savings
Performance Incentives

CIO/ACOs Provide the Clinical/Business Structure for Value-Based Networks / Plans



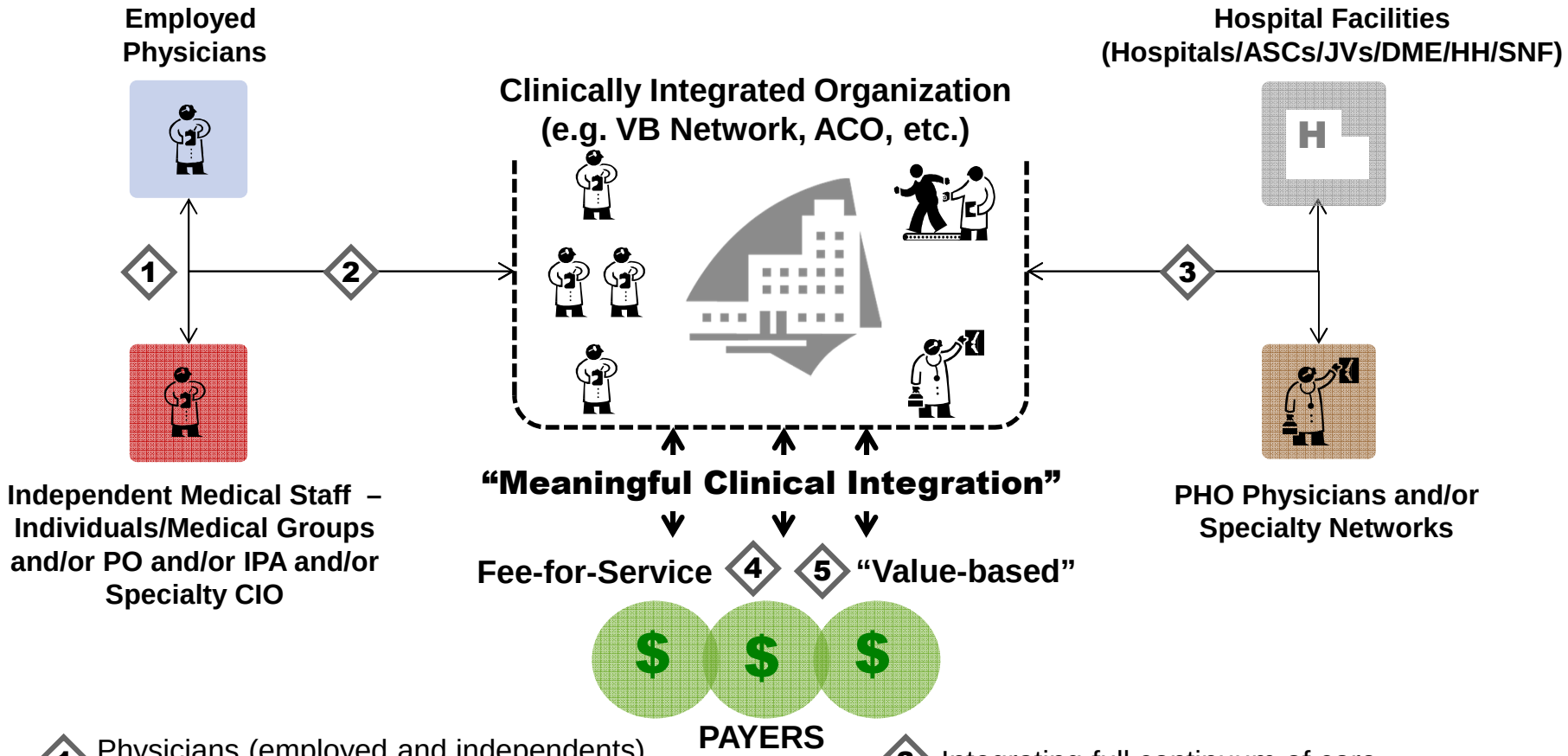
Minimum Requirements for an Integrated Health System Structure to be a CIO/ACO:

- Establish a state based legal entity such as an LLC, Taxable Non Profit, 501(c) 3, etc. that can enter into highly product specific contractual reimbursement relationships with selective use of FFS, **Value-Based,** Capitated arrangements, etc.
- Achievement of an FTC Compliant Clinical Integration Model to prioritize participation in 2014 State-Based Insurance Exchanges and additional Commercial "Value Based Product Offerings" for the individual and small group markets
- Support/Create transformational Clinical care models compatible with "next generation" Comprehensive Care Medical Homes, Collaborative Care, Health Services Exchange Capabilities, etc.

Definitions:

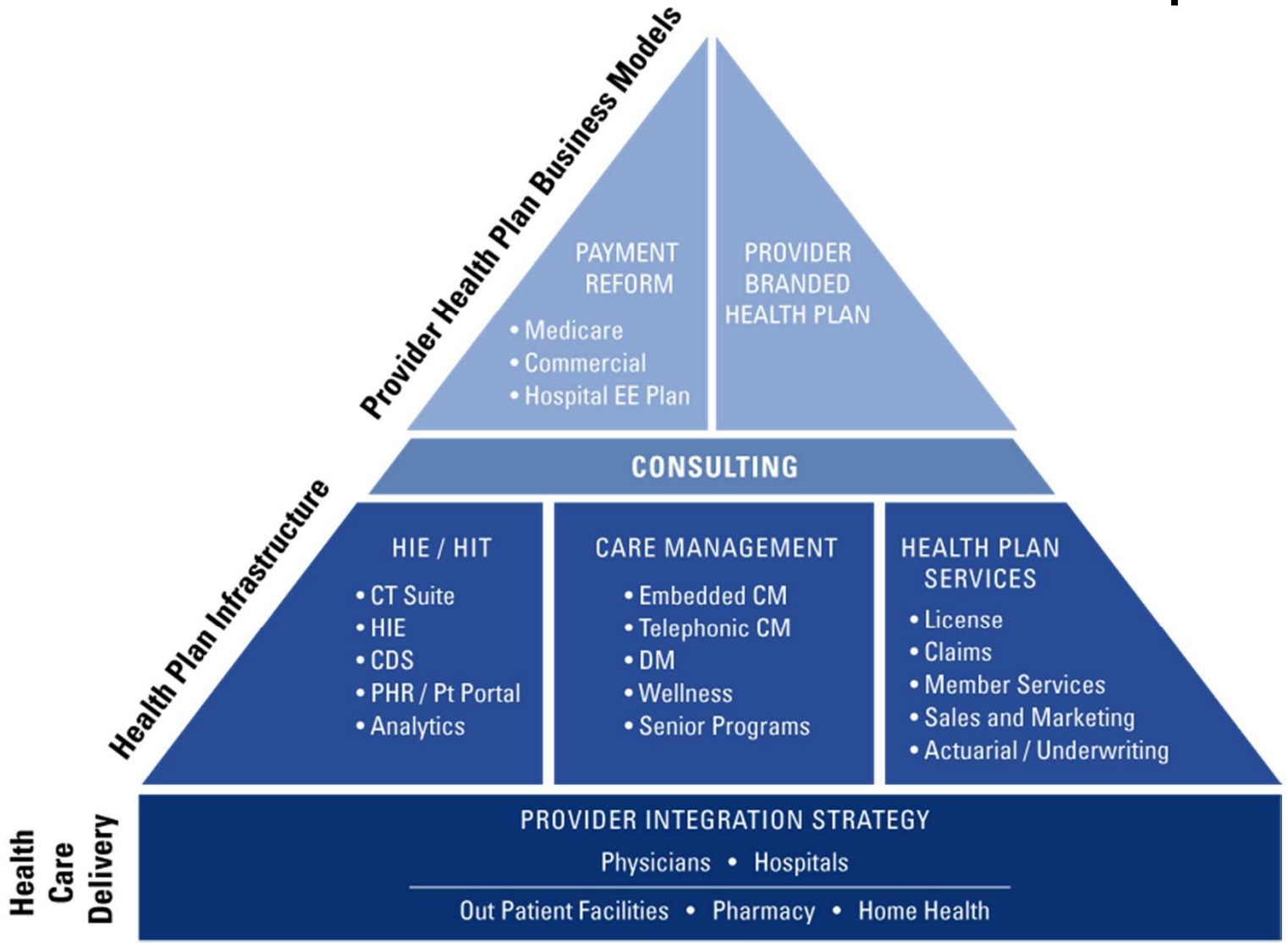
- A CIO is legal entity structured to hold contracts for any VB product (e.g., Commercial, Medicare SSP ACO, Medicaid, etc.)
- An ACO refers to a state based entity that qualifies for participation in the Medicare SSP ACO program but the term has been used interchangeably in CA, MA, etc. for state specific value based commercial programs (e.g., "MA ACO" Plan)

"Clinically Integrated Organization" Common Elements
– VB Plans Have Tiers of Lower Cost " Usually Smaller Networks"



1. Physicians (employed and independents) working together
2. Integrating physician practices with hospital practices
3. Integrating full continuum of care
4. Evolving interface between health system and payers requires clinical Integration
5. Patient-centric care

All Health Plans Have a CIO Integration Strategy for Developing Commercial VBPs and MSSP ACOs – Aetna Example



Core Payer Strategies Support ClO Development

Recurrent Themes from Large For Profit Health Plans

- United, Humana, Aetna, and Cigna are launching or will launch “Value-Based Plans”(VPNs) starting with existing core products: 1) ASO Employer Plans (CIGNA), 2) Medicare Plans (Humana, United); 3) Small, Mid Size and Large Group Employer Plans (United, Aetna, etc.); 4) Individual Market/State Exchanges (United, Aetna, Cigna, Humana, etc.) and Medicaid (United, Aetna, Cigna, Humana). All want dual eligibles due to their high cost. Select companies want Medicaid.

- Every major plan views VBPs as creating a lower price point option and very attractive to the employer/governmental payer in an environment with or without a formal retail (Exchange) market.

- Virtually all for profit plans see VBPs leading to more at risk or % of premium contracting with narrower networks.

- Health plans will employ/buy providers of all types especially PCPs/IPAs/POs

Risk Continuum for Existing and Proposed Payment Structures

Managing risk requires tiered networks

Tier I
FTC compatible meaningful clinical integration infrastructure-baseline large network

Tier 2
CIO network at least 15% smaller than tier I with more advanced CI capabilities

Tier 3
CIO network at least 30% smaller than tier 1 and capable of global payments with performance risk, p4p,etc.

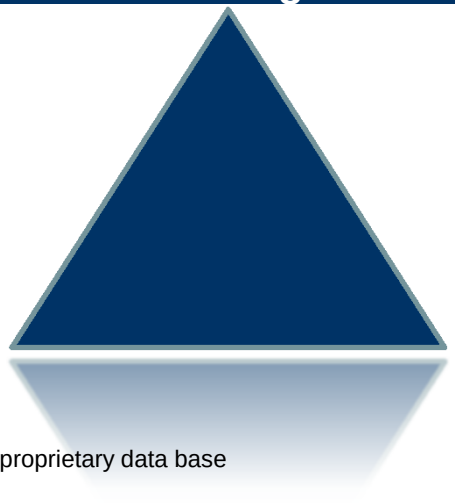
Tier 4
CIO network at least 45% smaller than tier 1 and capable of accepting global payment with financial risk (e.g. MA capability)

FFS

Financial Risk

Clinical Integration

- Consumers
- Employers
- Health Plans
- Government Payors



- Physicians
- Medical Groups
- Hospitals
- Other Providers

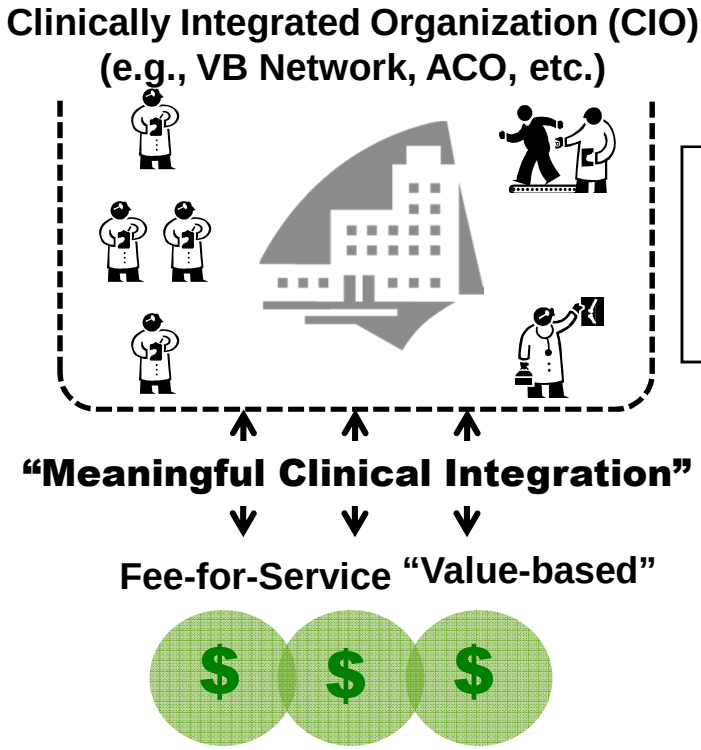
*Modified from HFMA materials with SSB Solutions, Inc. proprietary data base

Payer and CIO Tiered Narrow Network Structures for VBPs*

	MSSP ACO ASO	Medicare Advantage	ERISA EE Plan	State Based Exchange	Non Exchange Value-Based/ Narrow Network
Commercial and MA Products					
▪ **United**					
— Small & Mid Size Group	Tier 2/3		Tier 2/3	Tier 3	Tier 2/3
— Large group	Tier 2/3		Tier 2/3	Tier 3	Tier 2/3
— Medicare Advantage	Tier 2/3	Tier 4			
▪ **BCBS**					
— Individual	Tier 2/3		Tier 2/3	Tier 3	Tier 2/3
— Small & Mid Size Group	Tier 2/3		Tier 2/3	Tier 3	Tier 2/3
— Medicare Advantage	Tier/ 2/3	Tier 4			
▪ **Cigna**					
— Mid Size & Large group	Tier 2/3		Tier 2/3	Tier 3	Tier 2/3
— Medicare Advantage	Tier 2/3	Tier 4			
▪ **Aetna**					
— Mid Size &Large Group	Tier 2/3		Tier 2/3	Tier 3	Tier 2/3
— Medicare Advantage	Tier 2/3	Tier 4			
▪ **Humana**					
— Medicare Advantage	Tier 2/3	Tier 4			
▪ **ERISA / Hospital System Employee Plans**			Tier 1/2		
▪ **Medicare (Non MA Products)**					
— MSSP ACO	Tier 2/3				
— CMS Innovation					
— Pioneer ACO	Tier 2/3				
— Bundled Payment	Tier 2/3				
Medicaid (AHCCCS)				Tier 3/4	Tier 3/4

***Tier 1 Network- Minimal CIO Capabilities ----- Evolving to Tier 4 "Risk Products" (e.g., MA)**

FFS Payments vs. Value-Based/Shared Savings Payments vs. Economic Integration Payments



Health Plan / CMS Reimbursement Methodology

Standard FFS Payment
(No MCI)
(No EI)

"Value-Based" FFS Payment
(No EI)
– ACO
(MCI 1+)*
– No ACO
(MC 2+-4+)*

% Premium/ Capitation
(EI – No MCI required)

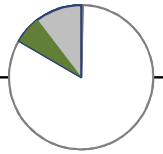
* 1+ MCI = Lower FTC MCI Threshold
4+ MCI = Highest FTC MCI Threshold

Funds Flow Model: Commercial VB Exchange Product (2014)

Commercial VB Exchange Product @ $383 PMPM

$0.15 — **Health Plans/CMS** — **$0.85**

Administrative Services



$0.10

Network

Clinical Operations

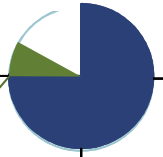
Marketing

Administrative Operations

$0.05

Profit / Contingency

Provision of Care Medical Loss Ratio



$0.21

Inpatient Services

$0.27

Physician Services

$0.27

Pharmacy and Outpatient Services

$0.10

Shared Incentives

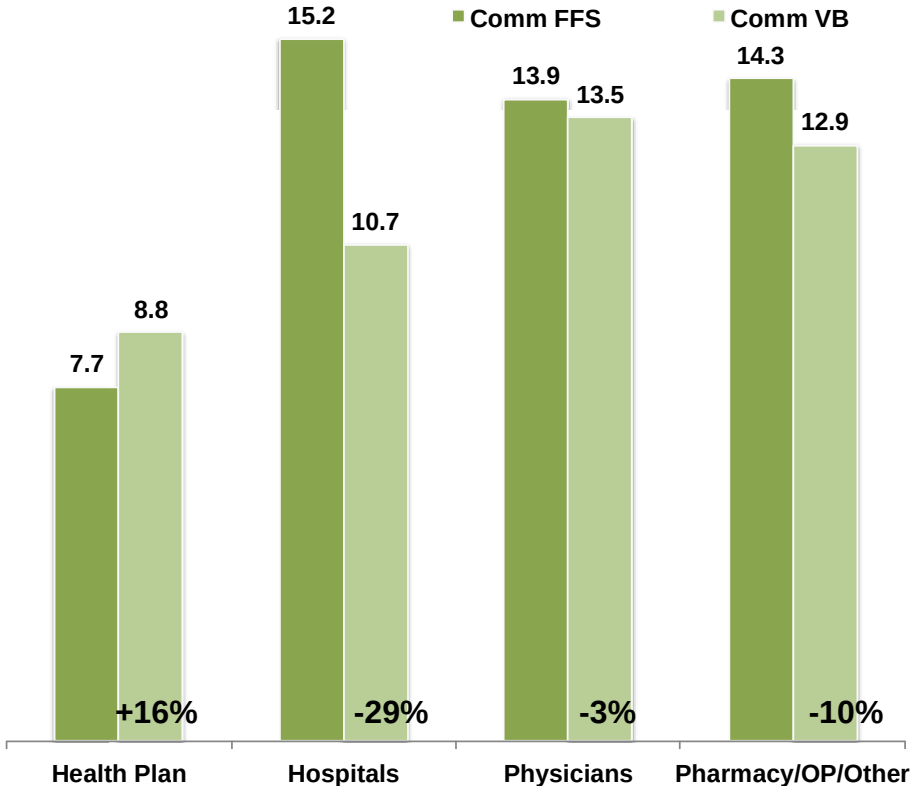
Commercial VB Exchange Product Revenue Allocation

Assume 10,000 enrollees at $383 PMPM

$45.9MM in Total Premium Revenue

Health Plan	**$MM**
Administration	4.6
Profit	2.3
Total	6.9
Providers	
Hospital (Inpatient)	9.8
Physician Services	12.5
Pharmacy/OP/Other	12.9
Total	35.1
Incentive Allocation	
Health Plan (50%)	2.0
Hospitals (25%)	1.0
Physicians (25%)	1.0
Total	4.0

Financial Impact on Key Stakeholders
Commercial FFS vs. Commercial VB Exchange ($MM)



Commercial VB Exchange Product (Severity-Adjusted)

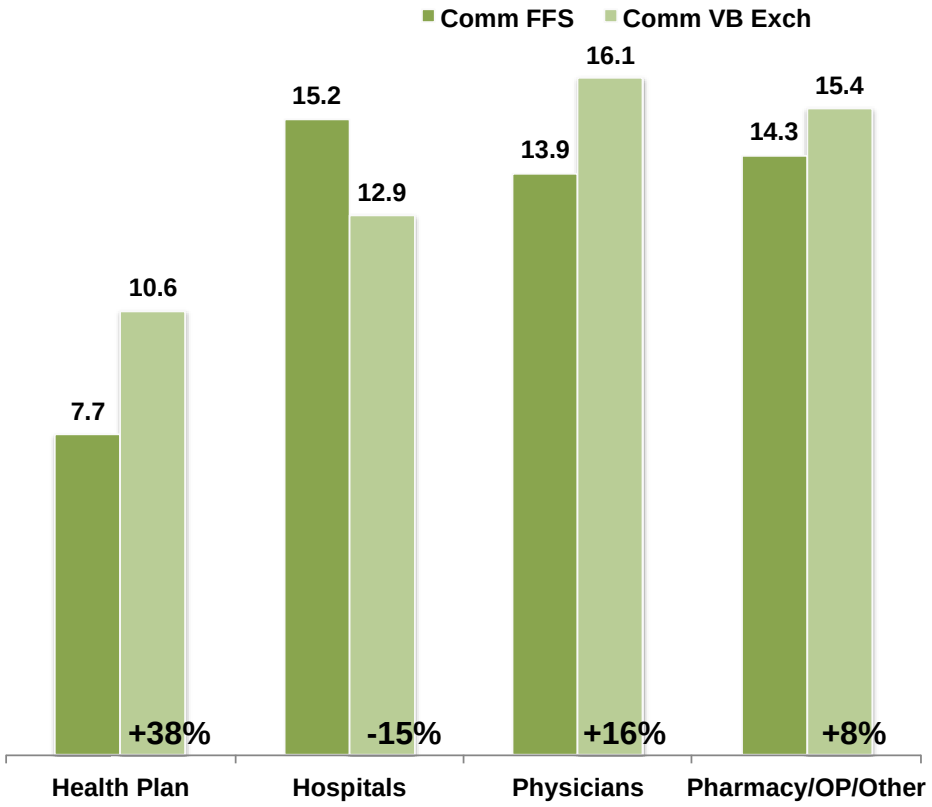
Assume 10,000 enrollees at $460 PMPM

$55MM in Total Premium Revenue

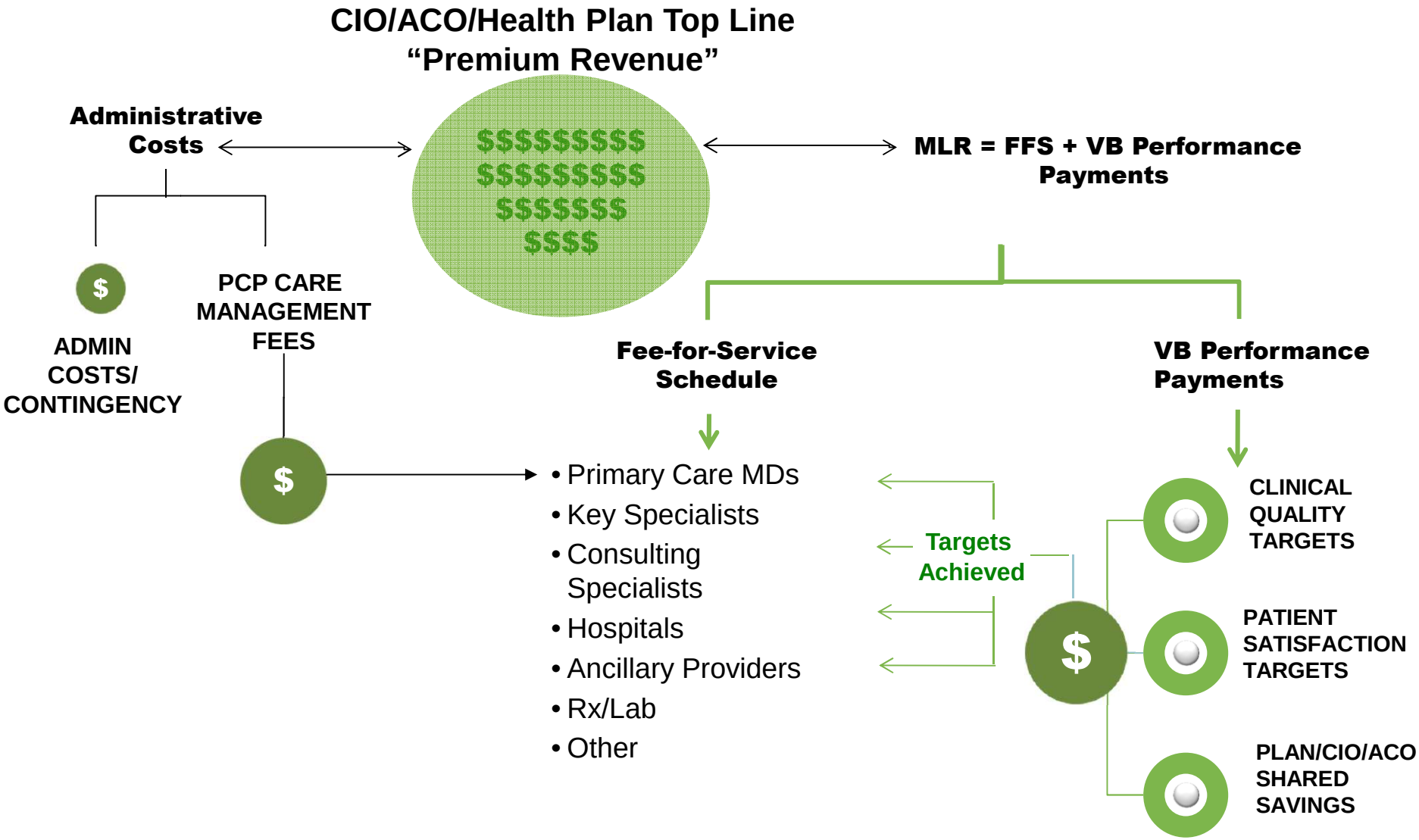
Severity-adjustment +20%

Health Plan	**$MM**
Administration	5.5
Profit	2.8
Total	8.3
Providers	
Hospital (Inpatient)	11.7
Physician Services	15.0
Pharmacy/OP/Other	15.4
Total	42.1
Incentive Allocation	
Health Plan (50%)	2.3
Hospitals (25%)	1.2
Physicians (25%)	1.2
Total	4.7

Financial Impact on Key Stakeholders
Commercial FFS vs. Commercial VB Exchange ($MM)



FFS "Value-Based" Reimbursement Model
– 5 Source MCI Provider Revenue Stream VBP Example

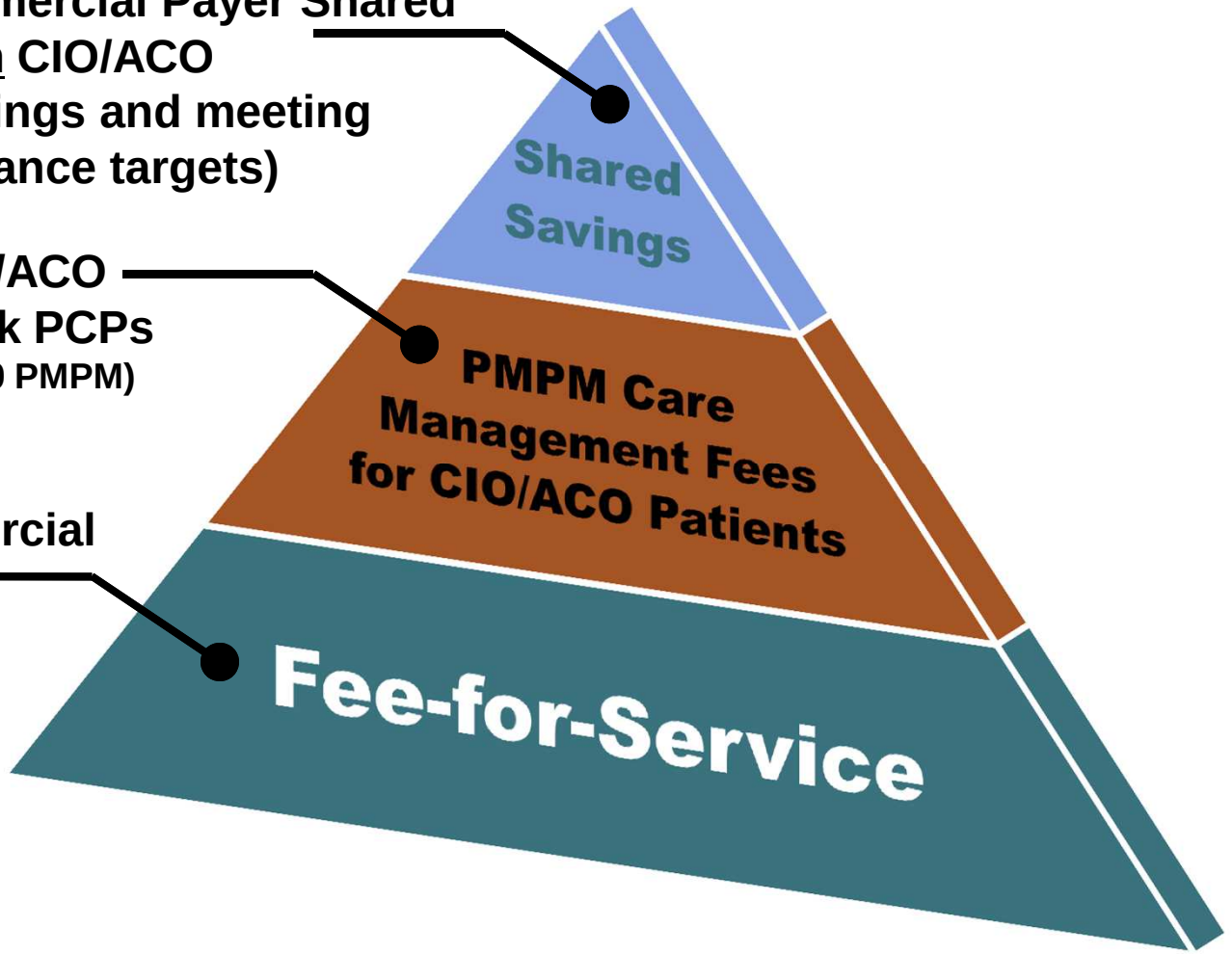


Summary of Value-Based Reimbursement Structure

From CMS/Commercial Payer Shared Savings through CIO/ACO (by creating savings and meeting defined performance targets)

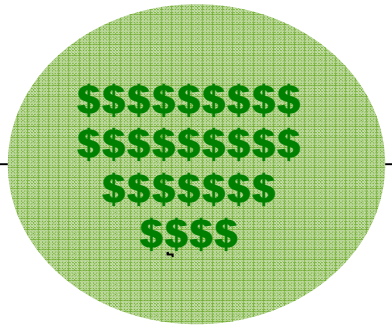
From CIO/ACO to Network PCPs ($5.00-$10.00 PMPM)

From CMS/Commercial Payer to Hospitals and Physicians (in ordinary course)



Value-Based Incentive Payments Are Distributed to Providers According to Rules Set by the CIO/ACO

VBP Incentive Payments For Distribution = Quality Incentive Fees, Patient Care Incentive Fees, Shared Savings, etc.



X%
Physicians

Specialist Groups

PCP Groups

CIO/ACO value based reimbursement is based on mutual shared savings and meeting quality metrics

- ACO has 33 VBP metrics
- Some commercial-based products pushing towards 100 VBP metrics with 20-35 having quantitative actuarial value
- Medicaid will eventually migrate to VBP metrics (e.g., 39 other states and expanding)

Y%

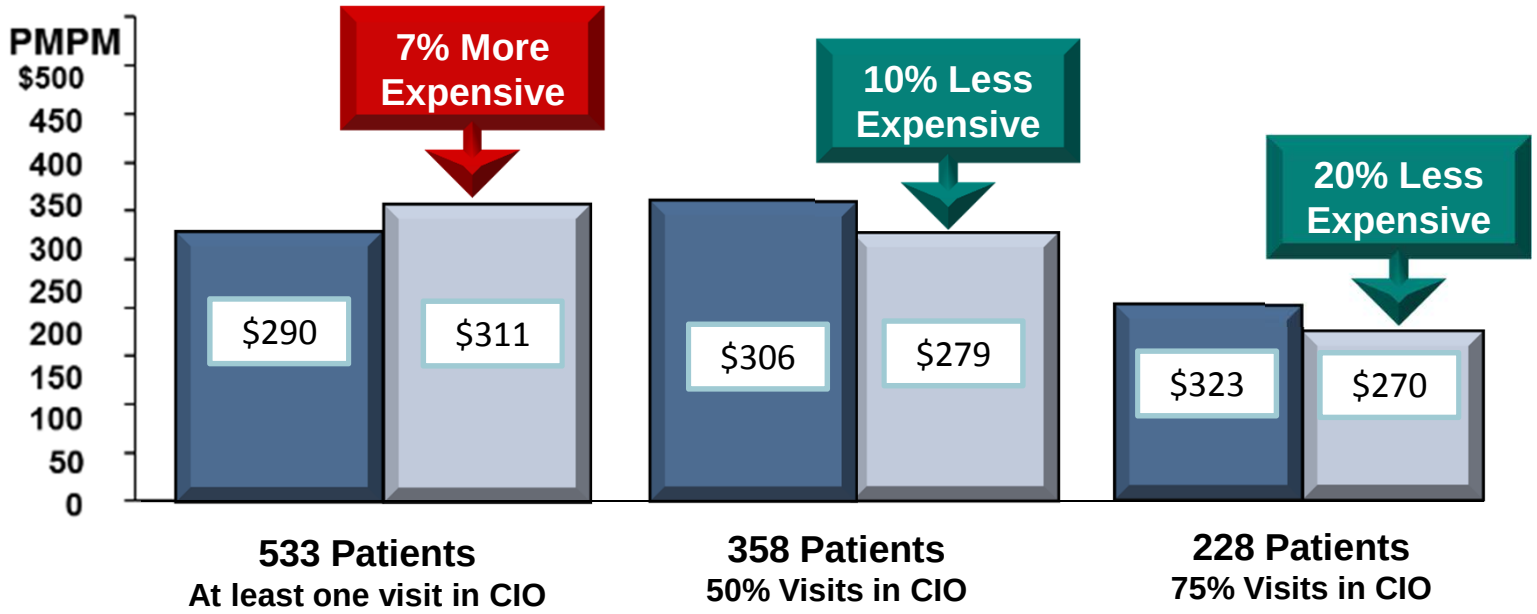
Hospital

North East Medical Group / BC Value-Based Pilot 2012

Key Issues = More Patient Contact – Less Total Cost

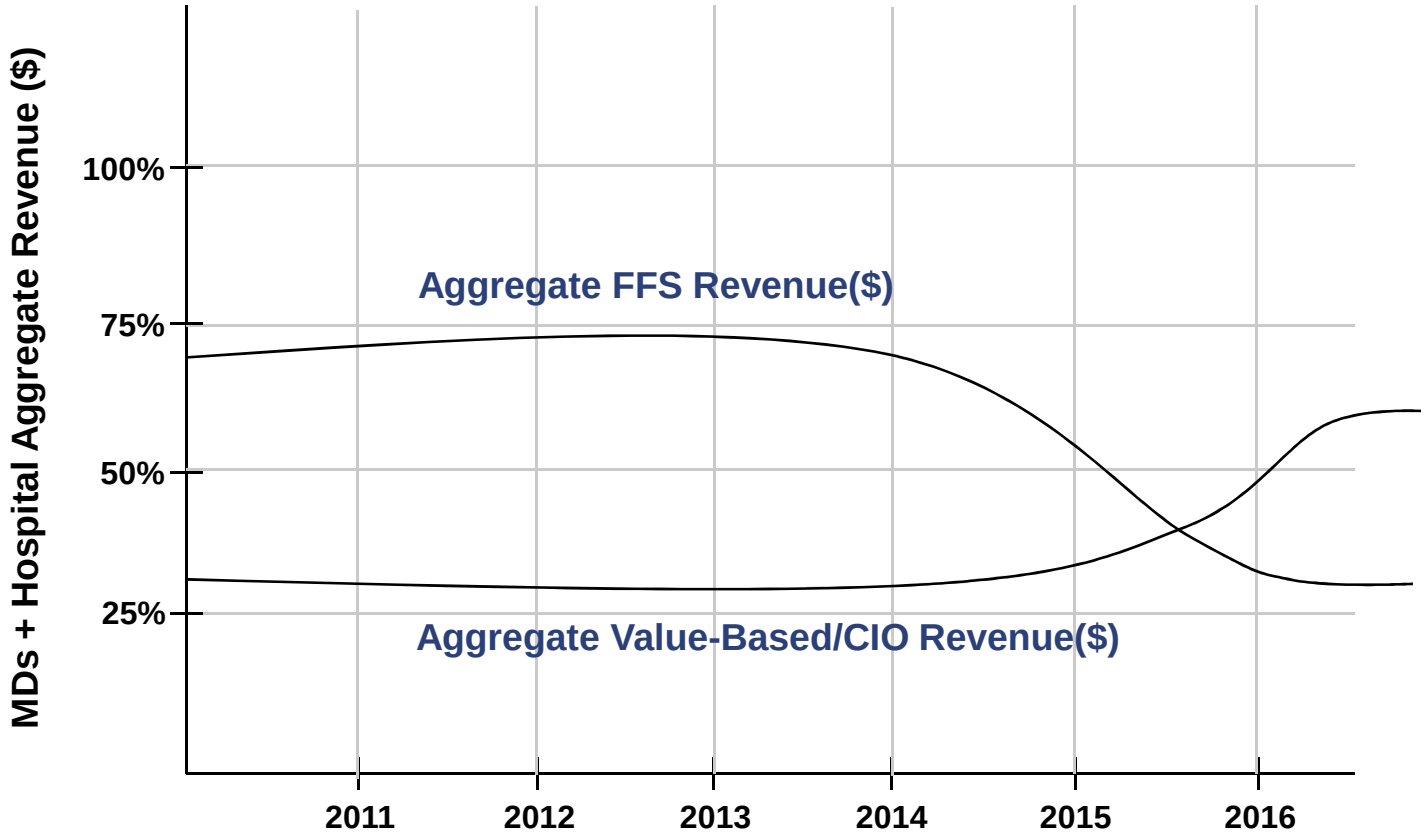
- Quality Data Monitoring Challenges
- Attribution should be at 75% for Maximum Bonus

Risk Adjusted Allowed (PMPM)



Managing Reimbursement Increasingly Complex

Alternative reimbursement methodologies will occur simultaneously and require different types of physician/hospital alignment models



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Governance/Management/ Operational Structures for CIOs and ACOs

– The “Optimal” Clinical Model

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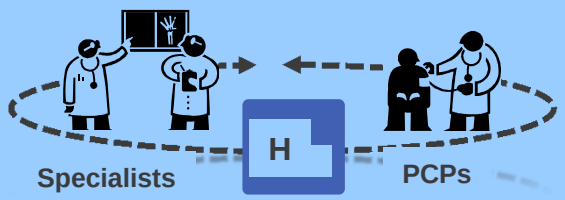
Clinically Integrated Organization (CIO) Formation

Requires At Least Four Discrete Projects or Processes

CIO Administrative Project
- Legal structure
- Organization
- Governance
- Committee structure
- Infrastructure development
- Budgeting/Financial Modeling

Clinical Model / Model of the Future
- Faculty
- Provider Compensation
- Clinical Transformation
- Enabling Technology
- Mobility of Care Elements in non-traditional settings
- Seamless transitions of care

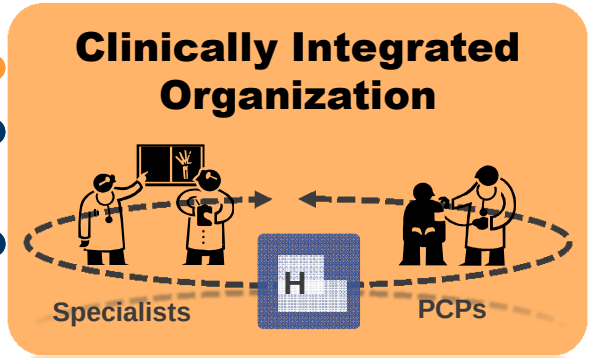
Clinically Integrated Organization (CIO)



Physician Engagement Project
- Education
- Engagement
- Physician Organization Development? Yes/No
- Aligned & Non-Aligned Physician Dynamic

Medical Staff Collaboration Project
- Education
- Engagement
- Structure for collaboration?
- Delegated Functionality

Up to Four Planning Tracks Underlie CIO Formation



Collaborative

Physician-Led

TRACK 1
Organizational Planning for CIO

- Analyze contracting opportunities (population; risk)
- Define legal structure
- Define governance
- Define management structure/responsibilities
- Determine infrastructure requirements and fulfillment strategy
- Develop budgets and financial models

TRACK 2
Planning for independent Physician Organization (can be concurrent w Track1)

- Clarify for physicians the rationale for change
- Engage physicians in the change process
- Define PO legal structure and governance
- Determine relationship and ownership interest in CIO
- Manage diverse stakeholder interests

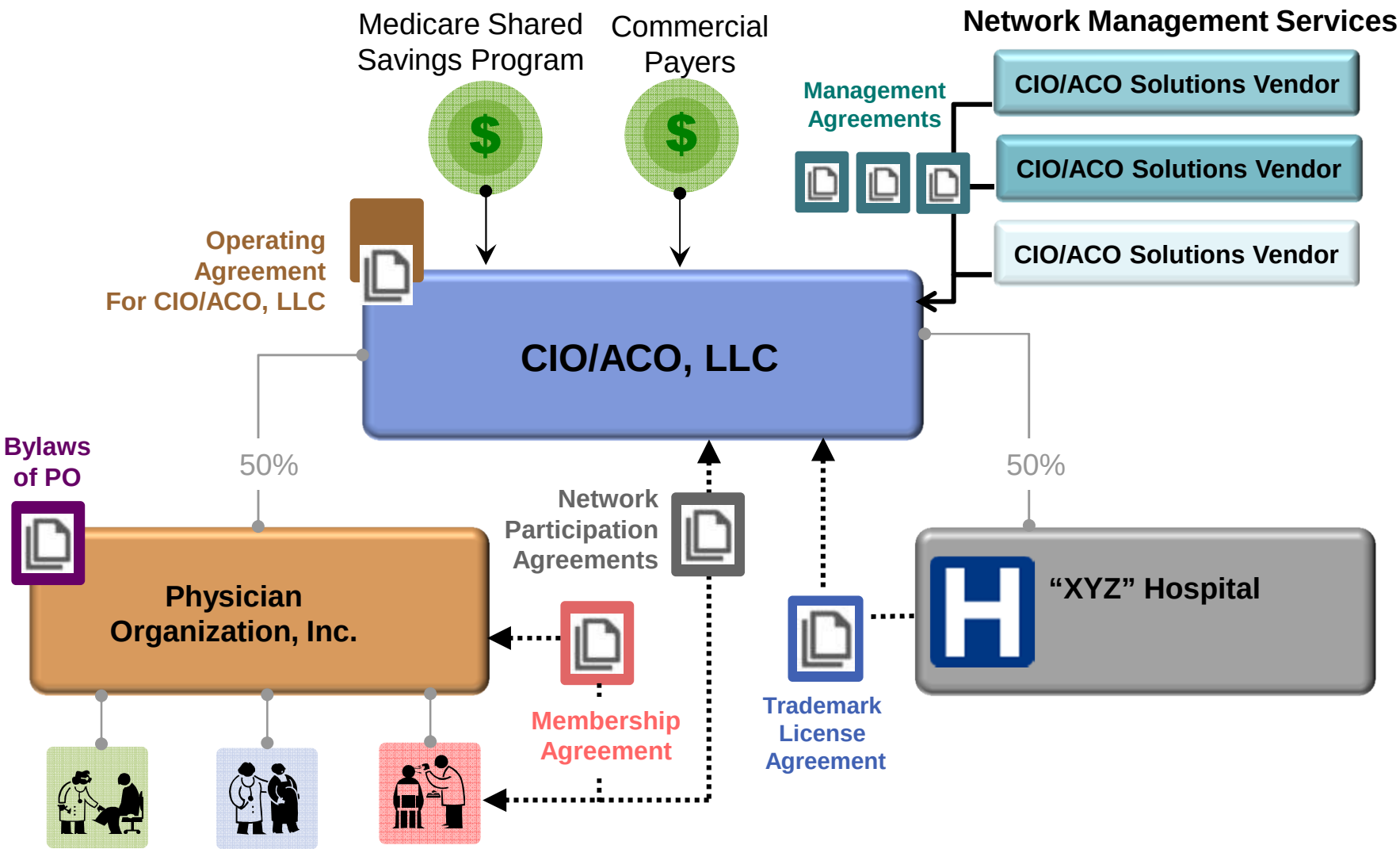
TRACK 3
Developing New Clinical Models

- Qualify & engage network participants
- Align clinical goals with provider compensation
- Design and promulgate evidence-based guidelines
- Minimize unnecessary practice variation
- Track clinical outcomes across continuum of care
- Integrate enabling technologies

TRACK 4
Collaborating with Medical Staff

- Educate and engage medical staff leadership on CIO strategy
- Align functionality across the continuum of care (quality, credentialing, peer review)
- Delegated Board authority for quality
- Governance/mgmt. of “all things clinical”
- Clarify role of MEC(s)

Key Agreements Required for CIO/ACO Formation – Example



CIO/ACO – Governance Structure

CIO/ACO Steering Committee will guide development process until the LLC Board of Managers is formally appointed

CIO/ACO - Board of Managers

Proposed Board of Managers

- 6 Managers from Hospital
- 6 Physician Managers
- Additional participants
  - Executive Director
  - Chief Medical Officer

Subcommittees

Quality and Clinical Integration

- Credential network providers
- Develop clinical protocols and performance initiatives by specialty
- Monitor and intervene as needed to improve clinical performance
- Set clinical integration priorities based on performance tracking
- Ensure clinical performance monitoring, decision-support and analytics align with organizational priorities

Finance

- Determine and monitor funds flow
- Review and recommend annual capital and operating budgets, for full Board approval
- Review monthly financial reports

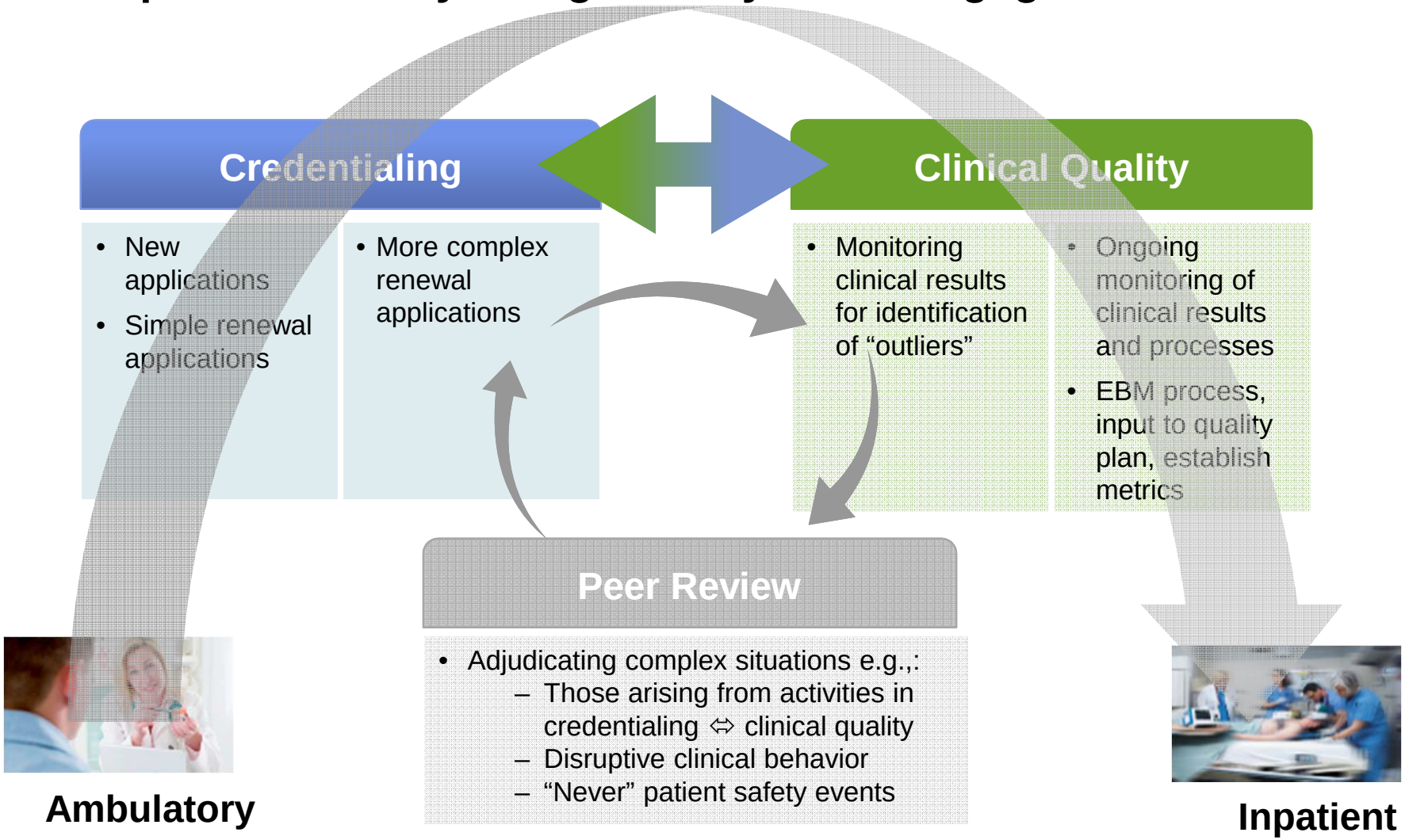
Operations and Contracting

- Oversee/review payer contracts
- Monitor operational performance and vendor relationships
- Work with Hospital to develop and oversee marketing and communication plans (physicians and patients)

Information Technology

- Oversee planning and implementation of IT infrastructure requirements

Key Clinical Functionality Across the Continuum of Care Requires Carefully Designed Physician Engagement/Process



A CIO/ACO Clinical Integration Committee (CIC) is the Forum for "All Things Clinical" and supports the Medical Staff

Key Components of Care Management Model

OUTREACH AND ENGAGEMENT

Health management

Wellness promotion

CHRONIC DISEASE MANAGEMENT

Disease management for patients with common health conditions

Case management for patients with multiple diagnoses compounded by social and behavioral issues

Catastrophic or complex case management

PHARMACY MANAGEMENT

Appropriate use of drugs

Prevent inefficient drug utilization

Prevent fraud, abuse and misuse

Reconcile medications between care settings

OUTCOME MEASUREMENT

Benchmarking and identification of best practices

Reporting of accurate, actionable and timely information

Patient and Provider Satisfaction measurement

PROCESS IMPROVEMENT AND INNOVATION

Define new approaches to improve outcomes

INPATIENT CARE

Identify patients admitted to IP and observation status

Use standard criteria for appropriate level of care and length of stay

Intensify focus on discharge planning

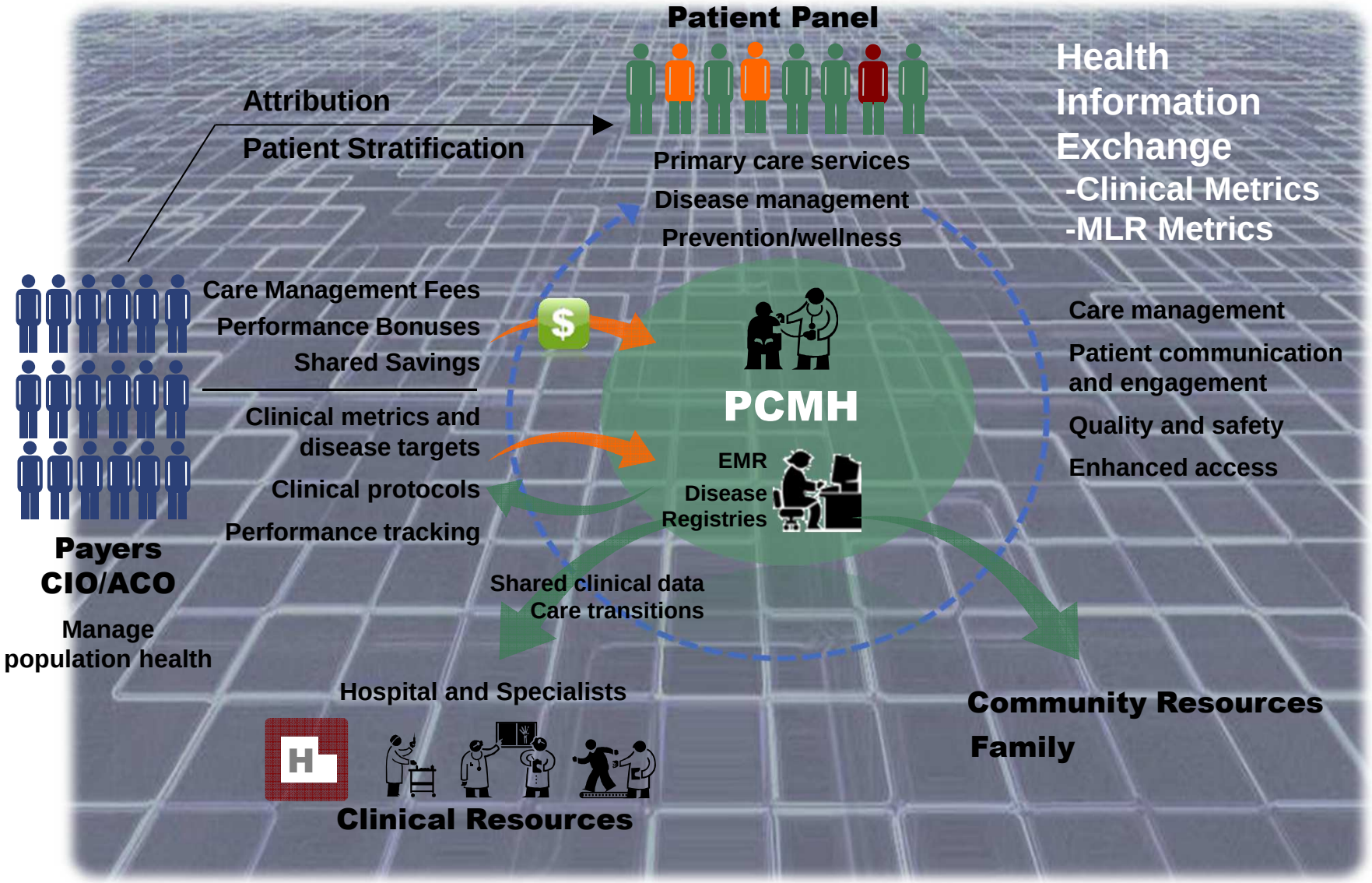
CARE TRANSITIONS

Manage patients care post-discharge

Coordination of care between providers and community resources

Prevention of avoidable re-admissions

CIO/ACO Medical Home Ecosystem



The CIO/ACO Healthcare Scheduling Exchange Becomes Critical to New Clinical Model and Business Model*

HIE and EMR

Personal Health Record

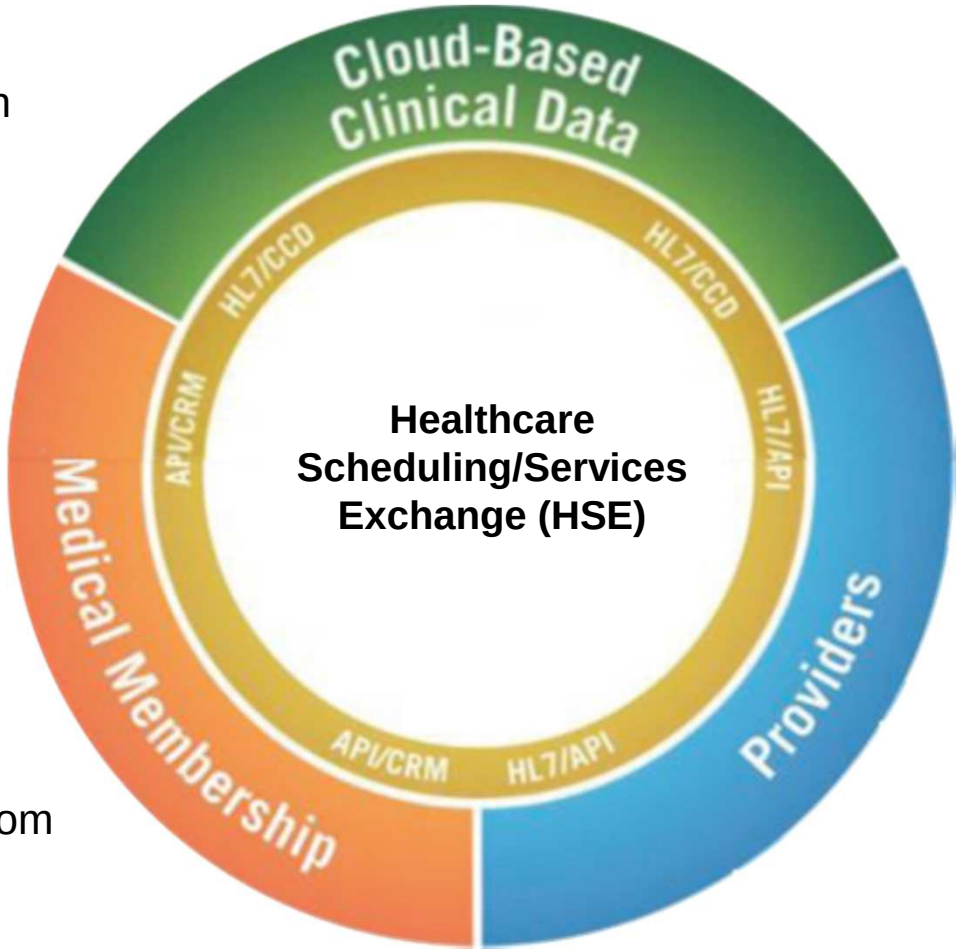
Chronic Condition

Wellness / Prevention

mHealth

Concierge Contact Center

myhealthplan.com



PMS and Clinical Decision Support

Claims/EDI

ACOs

Hospital HIS

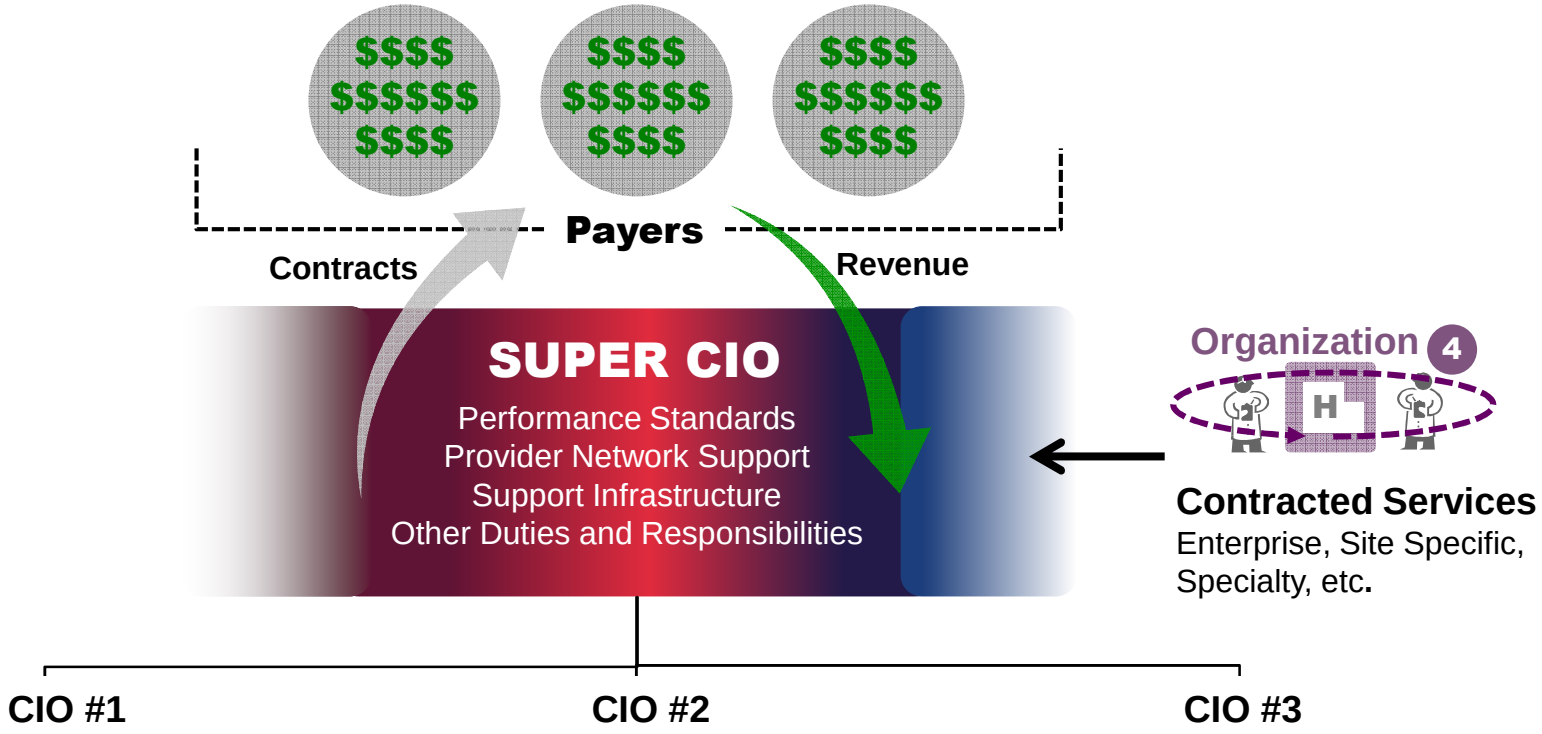
TeleHealth/ Collaborative Care

Primary Care Medical Homes

Specialists, Lab, ASC, Behavioral, Dental

* Adapted from MyHealthDirect

CIO/ACO Aggregation Is Facilitating "Super" CIO/ACO Creation



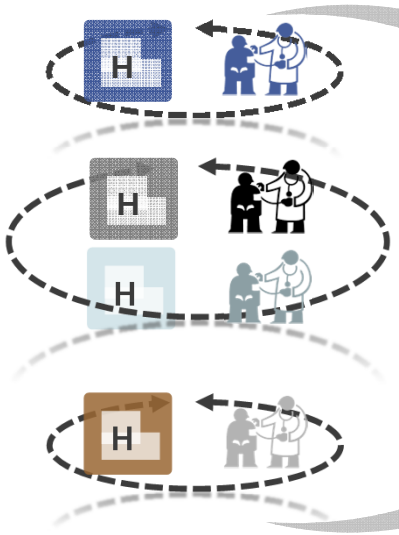
- CIO #1 Hospitals
- CIO #1 participating physicians
- CIO #1 Co-mgmt. Companies
- Other entities focused on clinical integration/performance

- CIO #2 Hospitals
- CIO #2 participating physicians
- CIO Co-mgmt. Companies
- Other entities focused on clinical integration/performance

- CIO #3 Hospitals
- CIO #3 participating physicians
- CIO Co-mgmt. companies
- Other entities focused on clinical integration/performance

CIOs/Super CIOs Competing for Payer and ACO Products

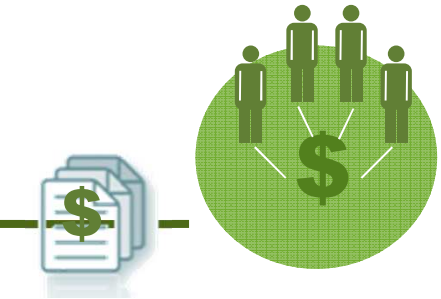
Competing CIOs and Super CIOs



HOW WILL PAYERS CHOOSE PREFERRED CIO PARTNERS?

- **Attractive geographic coverage**
- **Competitive price point**
- **Scope of clinical services/care model flexibility**
- **Superior performance on key network metrics**
  - Quality/patient safety
  - Appropriate resource utilization
  - Patient and provider satisfaction

Payer



Value-Based Products

- Targeted population
- Targeted benefit package
- Targeted payment mechanism

CIO COMPETENCIES

- Organizing fragmented, pluralistic physicians
- Addressing entire continuum of care (inpatient + outpatient)
- Creating advanced care delivery models

PAYER COMPETENCIES

- Knowledge of markets for insurance products
- Benefit plan design
- Marketing, enrollment and plan administration
- Claims processing

AMGA "High-Performing" Health System

A provider entity is considered a "High-Performing" Health System if it can demonstrate to the Secretary of Health and Human Services that it is conducting the following activities — AMGA Proposed Language

Key Elements:

- Efficient provision of services
- Organized System of Care
- Quality measurement and improvement activities
- Care coordination
- Use of information technology and evidence-based medicine
- Compensation practices that promote the above-listed objectives
- Accountability

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Medicare Shared Saving Program (MSSP) – A Snapshot

SSB Solutions

PROPRIETARY AND CONFIDENTIAL

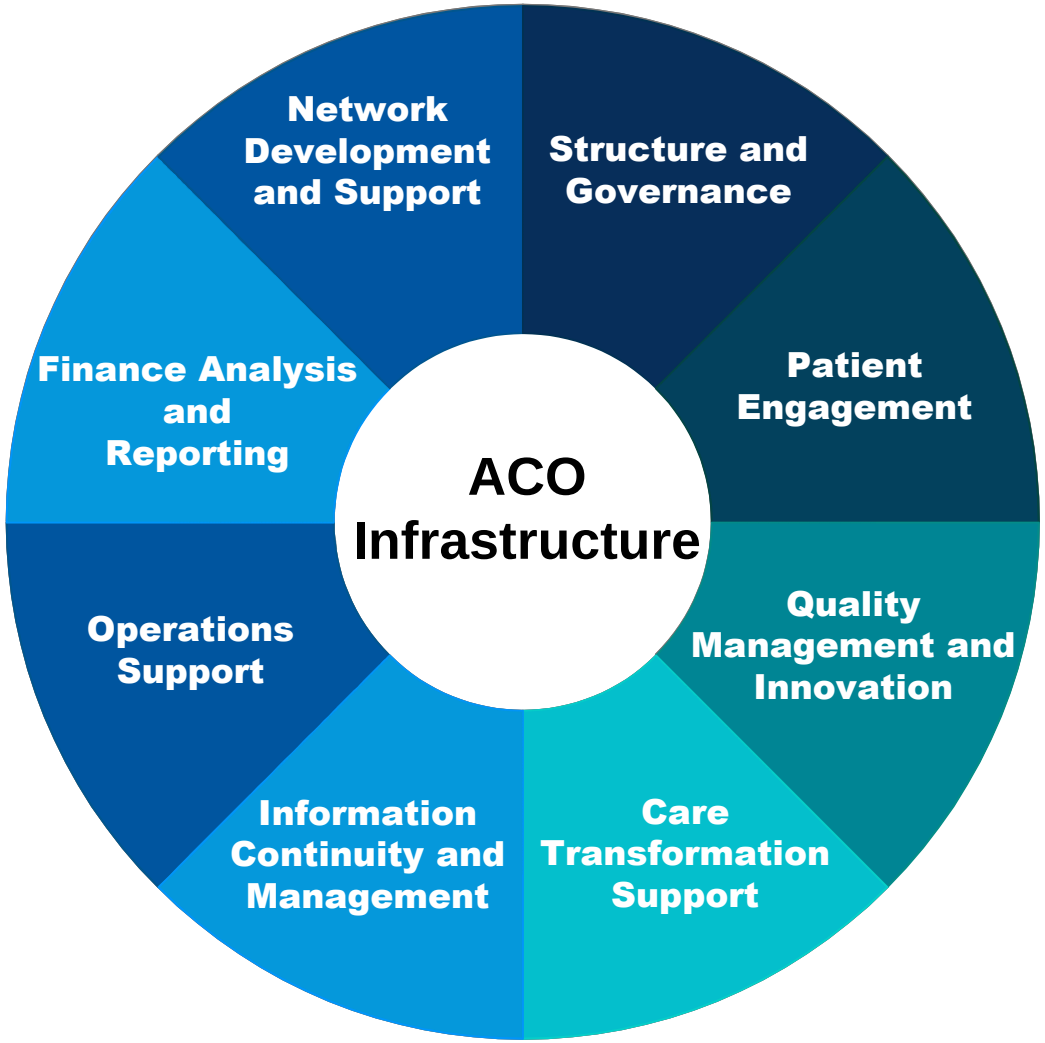
Snapshot of ACOs

Accountable Care Organization:

A "state-specific" formal legal entity that would allow the organization to receive and distribute payments for shared savings to participating providers of services and suppliers via the Medicare Shared Savings Program.

- Minimum eligibility requirements:
  - Legal structure and governance as required by MSSP final rules
  - Sufficient number of primary care physicians to have an assigned beneficiary population of at least 5,000 for a MSSP ACO
- Mandatory review from the antitrust enforcement agencies required only if ACO applicants fall outside of "safety zone" defined by final rule
  - If ACO enters into "value-based" commercial products it becomes a CIO and the special ACO specific antitrust exemptions must be re-reviewed
- Multiple types of ACOs:
  - Medicare Shared Saving Program ACO is the primary ACO model going forward with a go live target of January 2013. Physician/Hospital Shared Savings are capped at 10% of aggregate cost of patient care (e.g., 5,000 patients at $ 1,000 pmpm = $ 60 MM, so the max shared savings would be $ 6 MM minus administrative fees and development costs).
  - Two primary ACO models being developed by CMS.
- Other programs from the CMS Center for Innovation:
  - Pioneer ACOs
  - Bundled Payments (Global Payment and/or Packaged Payment)
  - Comprehensive Primary Care (Patient-Centered Medical Home), etc.

Necessary ACO/CIO Infrastructure



Selection of Management Services Organization(s)

- Identify vendors
- RFP process to evaluate capabilities
- Selection of MSO(s) for CIO/ACO

ACO Success Tied to Key CMS Performance Metrics

BETTER CARE FOR INDIVIDUALS

- ☑ Preventative Health
- ☑ Patient/Caregiver Experience
- ☑ At Risk Population: Hypertension
- ☑ Care Coordination Patient Safety
- ☑ At Risk Population: Ischemic Vascular Disease
- ☑ At Risk Population: Heart Failure
- ☑ At Risk Population: Diabetes
- ☑ At Risk Population: Coronary Heart Disease

BETTER CARE FOR POPULATIONS

Financial Model : Building Blocks for ACO Financial Model

ACO Revenues: Shared Savings from CMS

Population size

Performance scores

Savings achieved in delivery of care

Benchmark PMPY

ACO Expense Categories

Start-Up

- Consulting
- Legal
- Compliance training
- IT planning and implementation

Operating

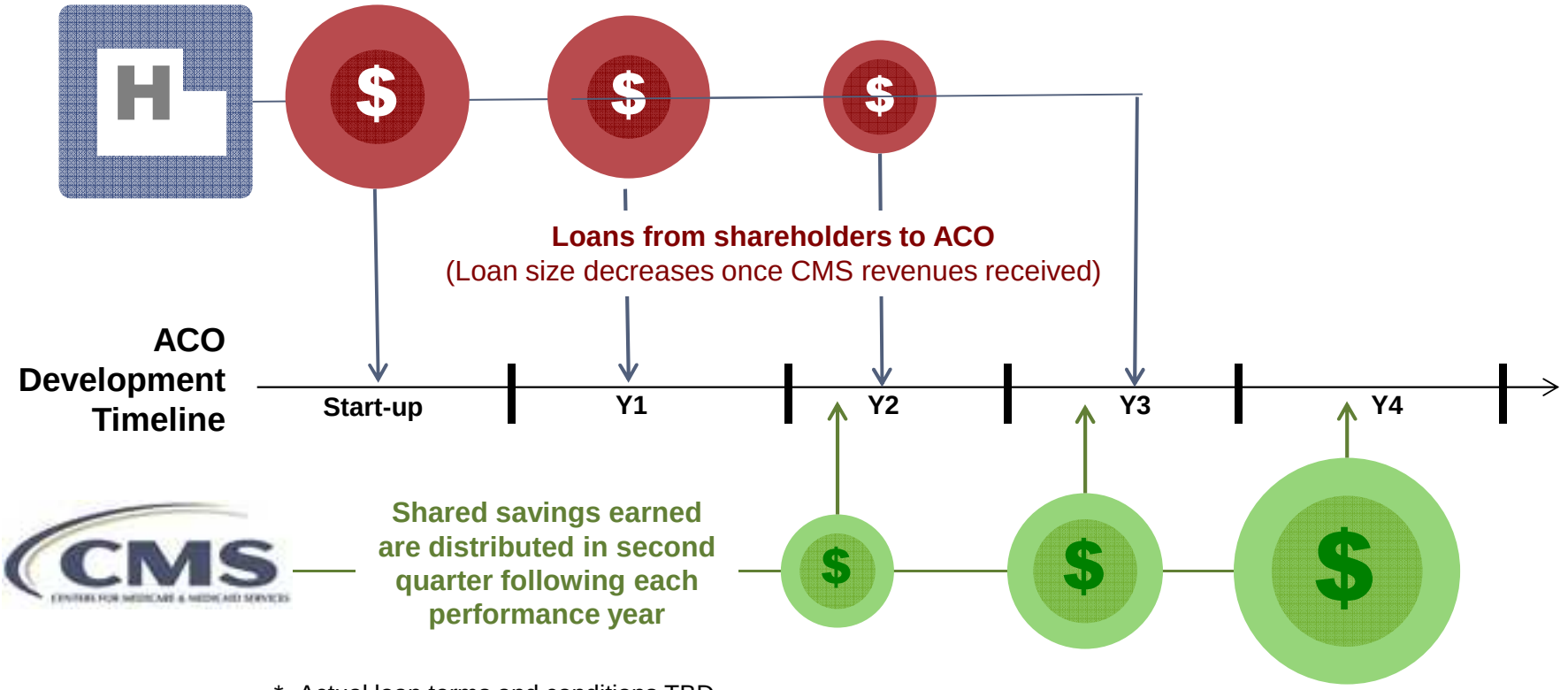
Staffing
- Care/quality management
- Administrative

Infrastructure
- Clinical support
- Network management
- Connectivity and analytics

Financial Model: Capitalizing the ACO

ACO financial model assumes the shareholders loan the ACO capital to cover selected start-up and working capital requirements

- Ultimate timing and scale of funding requirements is influenced by overall ACO performance and CMS payment schedule
- Financial model assumes interest only payments from ACO to shareholders through end of Y3; pay down of principal thereafter*



*- Actual loan terms and conditions TBD

MSSP Incentive Award Opportunity

Expenditure Reduction Achieved by ACO × **Performance Score Earned by ACO** = **MSSP Shared Savings Award Paid to ACO**

- Part A and Part B claims for beneficiaries attributed to the ACO
- Benchmark projection based on 3 years of CMS data

Patient/Caregiver Experience

☑☑☑☑☑☑☑

Preventative Health

☑☑☑☑☑☑☑

Care Coordination Patient Safety

☑☑☑☑☑☑

Managing At-Risk Populations

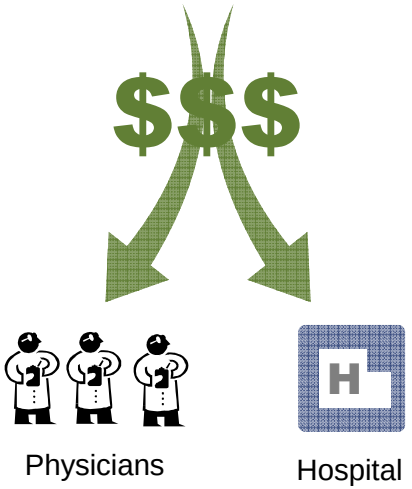
☑☑☑☑☑☑☑

☑☑☑☑☑☑

33 Total Performance Metrics

- In Year 1, requirement is complete and accurate reporting on all measures
- In Years 2 and 3, a performance score is calculated for the ACO

ACO Portion of Shared Savings



- Total award is capped at 10% of Benchmark expenditures
- Calculation of award occurs 4-6 months after end of year.

ACO – Illustration of Potential MSSP Funds Flow*

		Enrollment	Per Member Per Month	Aggregate Annual	Physicians' Share
Enrollment		5,000			
Medicare FFS Part A and Part B			$1,000	$60,000,000	
Total Savings:	20%		$200	$12,000,000	
Max Shared Savings:	50%		$100	$6,000,000	
Actual Shared Savings Performance Score:	100%		$100	$6,000,000	
Care Management Fee			$10	$600,000	$600,000
Administration Infrastructure Fee			$15	$900,000	
Net Savings			**$75**	**$4,500,000**	**$2,250,000**

*** 20% Reduction of Costs (Savings) with a Performance Score of "1" = 20% SSP Opportunity**

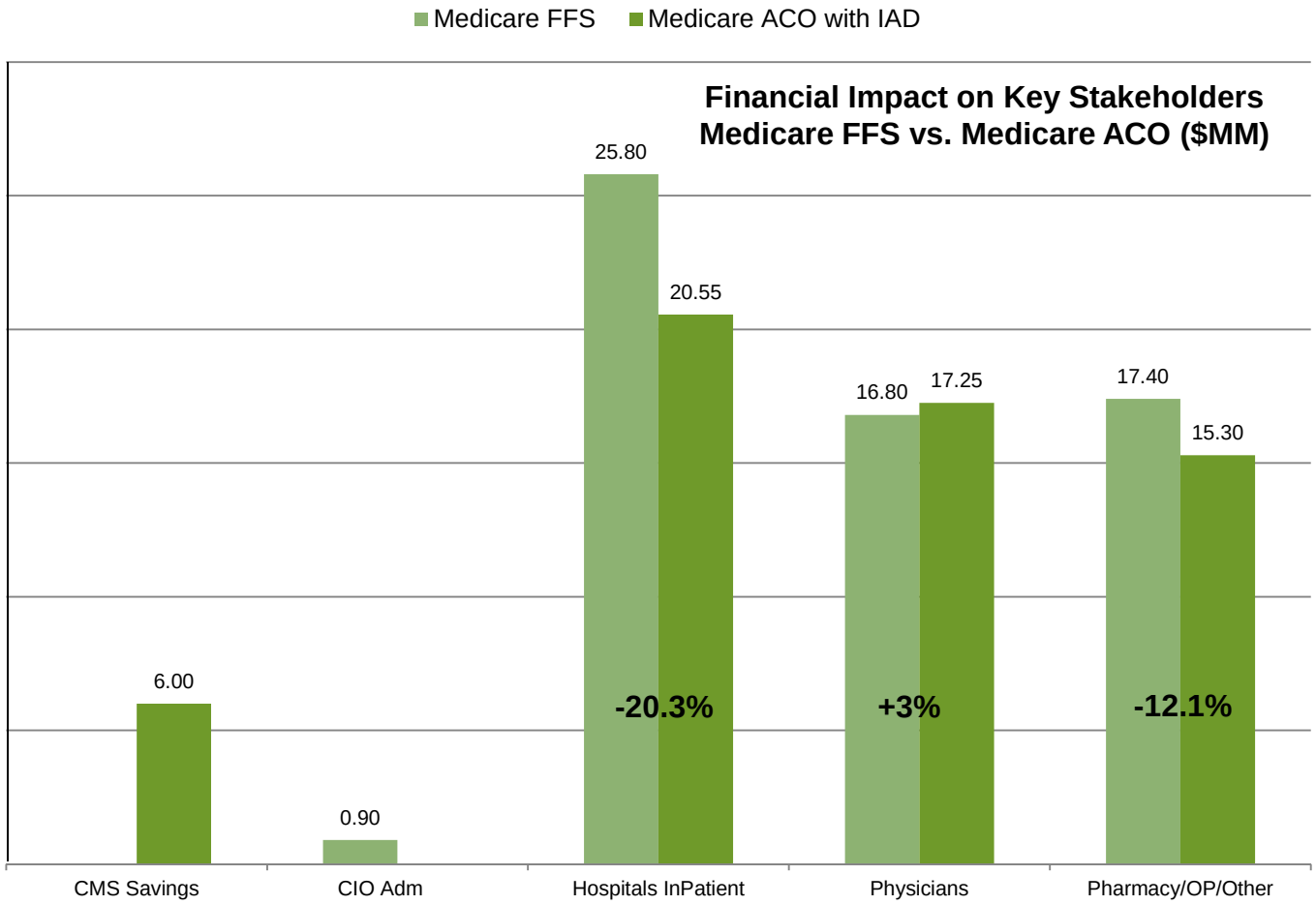
V1

MSSP ACO Revenue Implications – Defensive Rationale, Value-Based Product Capability and Market Share Strategy

Assume 5,000 enrollees at $1,000 PMPM

$60 MM in Total Premium Revenue / $12 MM in Maximum Shared Savings

CIO/Provider Costs	**$MM**
Administration/$15 PMPM	0.9
Totals	0.9
Provider Revenue	
Inpatient (Hospital)	18.3
Physician Services	14.4
Pharmacy/OP/Other	15.3
Totals	48.0
Incentive Allocation Distribution (IAD)	
CMS (50%)	6.0
Hospitals (18.75%)	2.25
Physicians (18.75%)	2.25
All PCP Physicians (5%)	0.6
Totals	11.1



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Conclusions and Enterprise Imperatives

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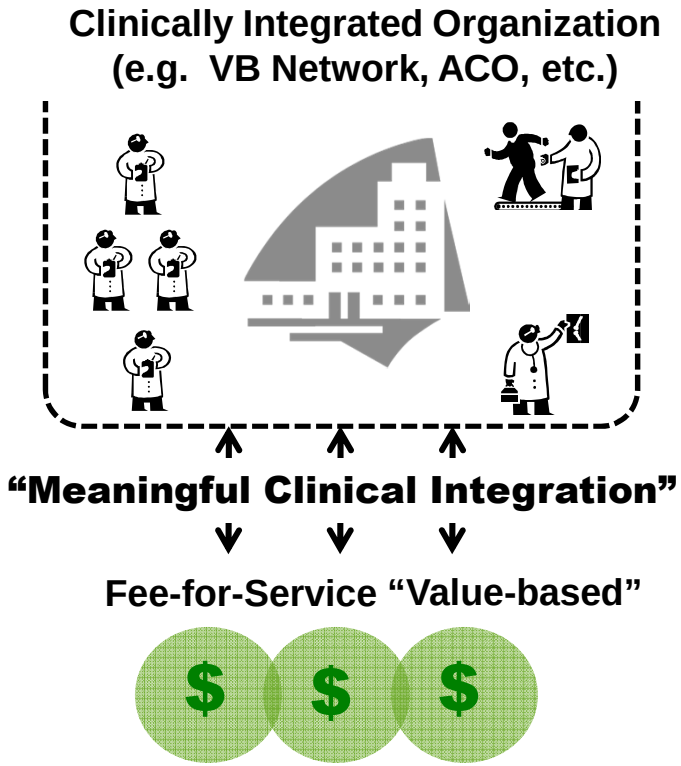
The Accelerated Push to Performance-Based Survival

- Incremental legislative/ regulatory changes
- Technology/IT challenges
- Delivery system rationalization
- MD/Hospital interdependence accelerates

- Patient Protection and Affordable Care Act 2010
- Delivery system size and market share
- Growing number of “uninsured”
- Physician/hospital and physician/physician aggregation/employment accelerates

- Meaningful Clinical Integration, value-based purchasing, physician leadership and engagement begin to take center stage
- Optimizing physician/hospital partnering opportunities becomes paramount:
  - Hospital-sponsored medical groups/MD employment
  - Co-management agreements and specialty CIOs
  - Value-based network structures
  - Super CIOs begin to form

The Clinically Integrated Organization Requires Physician Leadership and Engagement



CIO Physician Leadership Requirements

- **Governance:** Physician Leadership at the Board of Managers (LLC) or Board of Directors plus Board Sub Committee Leadership (e.g. Quality)
- **Management:** A strong physician leader is "key" to accelerating and managing physician engagement at all levels
- **Operations:** Medical Group/IPA/Network clinical and financial performance is driven by physicians clearly understanding what clinical and financial endpoint expectations
- **CIO/ACO:** Very specific Physician Leadership needs related to sophisticated product specific care models for complex senior and special needs populations
- **Commercial VBP Exchange Products**: Physician Leadership required to meet VBP targets

Enterprise Imperatives

Building a Performance Driven Clinically Integrated Organization

1) **"Do Not Try This At Home, Expert Supervision Required"– Ian Morrison, AHA Health Forum Leadership Council Summer 2012.**

2) **Physician engagement and the clinical model** — a balance of care delivery drivers, changing reimbursement and meeting growing a growing number of quality metrics/requirements will drive everything.

3) Rigorous business planning and financial modeling must support the Health Plan/CMS payment methodologies
   - Know the rules of the financial model, risk exposure and funds flow specifically for your organization and potential VB product participation.

4) Enterprise (physician/hospital entities) success factors inevitably include **critical mass**, clinical competency, physician leadership, system connectivity and active management of the transition to value-based reimbursement.

5) CIOs/ACOs/Super CIOs must be carefully developed and must be a separate legal entity that pass FTC regulations. Antitrust Issues loom large for FFS clinical integration strategies especially because optimal models depend on data integration, reporting capabilities and ultimately a unified contracting capability.

6) Successful patient engagement Model is critical.

Clinical Integration Investment and New Market Tax Credits

Types of Clinical Integration Investment

Infrastructure
IT upgrades
Patient navigators
Clinical team support

Physician Alignment
HSMG development
Co-management
Physician partnerships

Facility
OR upgrades/expansion
New or expanded MOB
Outreach clinics

Federal government's New Market Tax Credits can significantly reduce overall cost of clinical integration investment for qualified entities

- $36 billion program to drive economic growth in economically-challenged areas
- Represent significant source government-subsidized capital for 1,000+ qualified hospitals
  - NMTCs, hospital investments can qualify for 15-18% subsidy from federal government, significant reducing overall project cost
- Tapping NMTCs requires significant consulting, legal and accounting expertise to structure deal and access credits, the majority of which is paid once NMTC deal is closed

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Appendix
– Building an ACO Medicare Shared Savings Program

SSB Solutions

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Snapshot of ACOs

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- Other programs from the CMS Center for Innovation:
  - Pioneer ACOs
  - Bundled Payments (Global Payment and/or Packaged Payment)
  - Comprehensive Primary Care (Patient-Centered Medical Home), etc.

Summary – CIO/ACO Development Project

- Development ,organization and implementation of a CIO/ACO in order to participate in CMS Medicare Shared Saving Program on January 1, 2013.
- Potential expansion to include contracting with commercial payers later in 2013 (with some modifications of organization structure possible).
- The immediate priority for CIO/ACO is to organize necessary business and clinical planning to support completion of the filing of a Medicare Shared Savings ACO application by September 6, 2012.
- The ACO development process will focus on:
  - Development of the organizational structure supporting the ACO, including governance and management considerations
  - Medical management and other infrastructure requirements
  - Selection of one or more Management Services Organizations (“MSOs”)
  - Financial and resource analysis
  - Other applicable ACO application requirements

Required Organizational Competencies for CIOs/ACOs

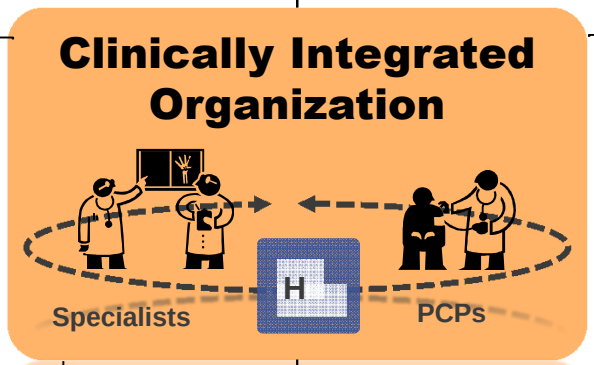
Value-based CIOs require essential capabilities to maximize operational and financial success

Organizational Structure and Leadership

Create a "one enterprise" culture with shared accountability and risk/reward

Network Development

Develop and mature the CIO network to meet payer needs and enable maximum health system flexibility/options



Care Delivery Transformation

implementation of evidence-based practices, patient engagement, seamless care transitions, and capacity optimization.

Payer Engagement

Short Term
Add sufficient size and scope to the delivery system to enhance its attractiveness to payers.

Intermediate Term
Collaborate with government, private payers, and employers to reward value and build accountability for managing healthcare quality/costs.

Physician Engagement

Educate and engage physicians to participate energetically in CIO leadership and leadership of the clinical model transformation.

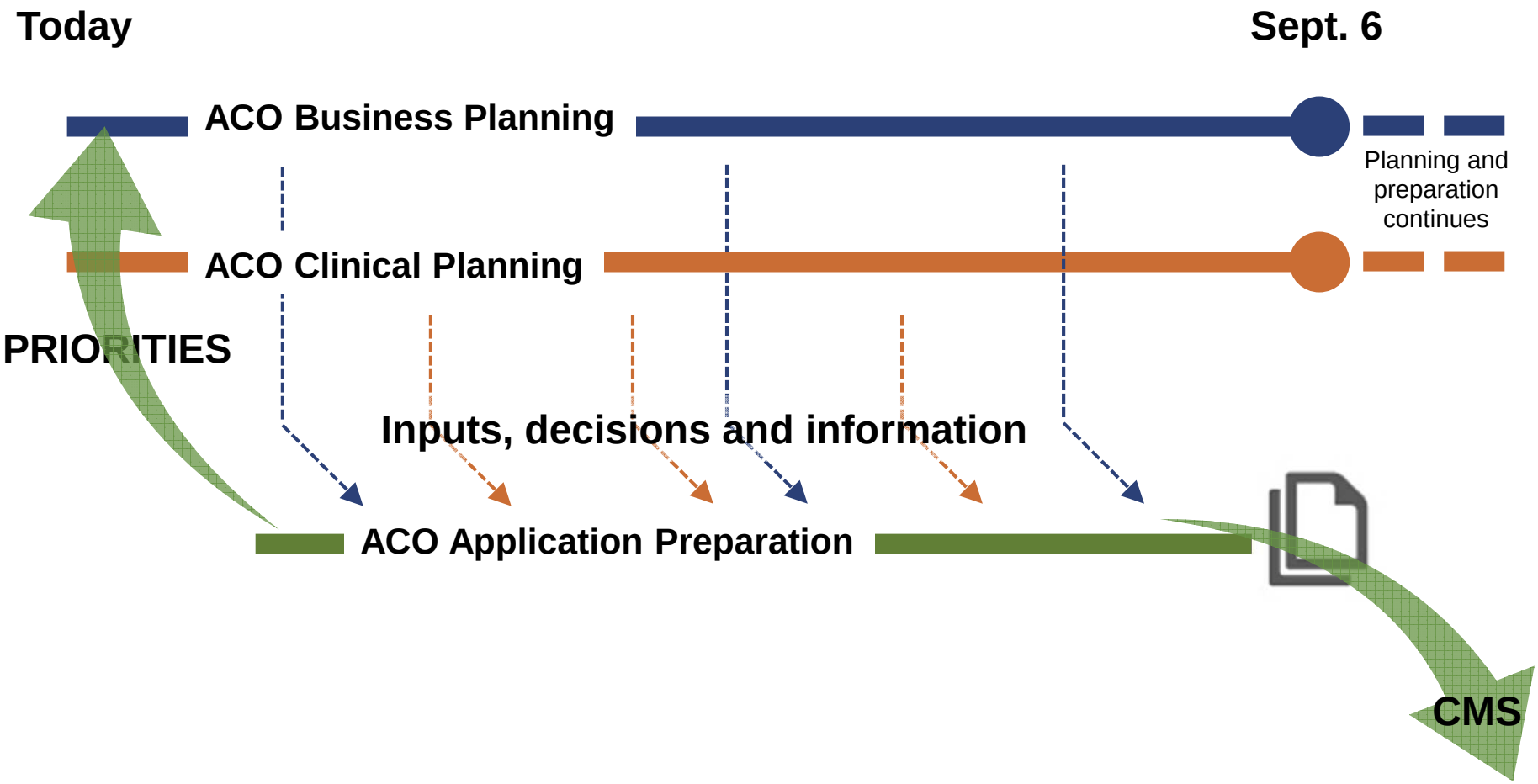
Financial Modeling

Understand start-up and operating budget; 3-5 year financial projections.

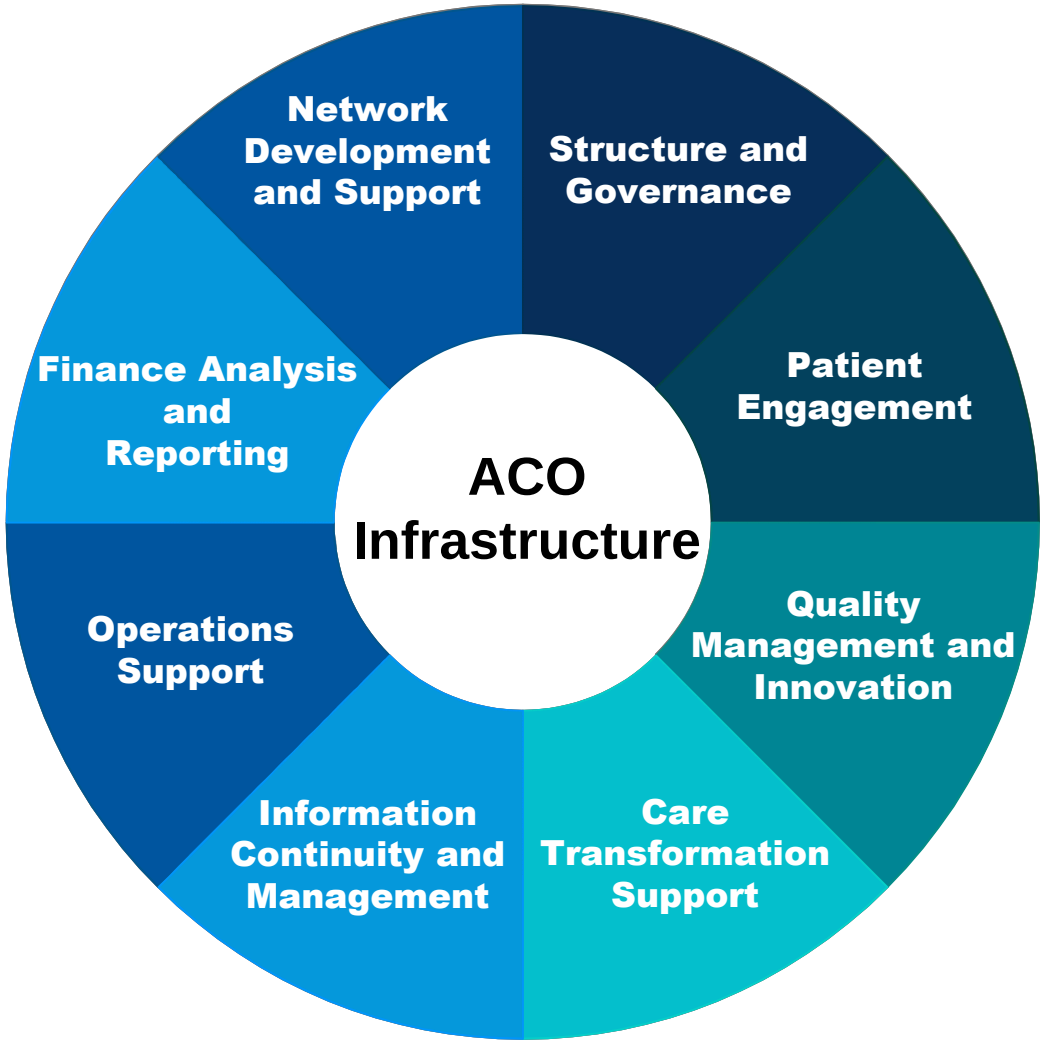
CIO Infrastructure

Administrative services
Budgeting/financial modeling
Clinical model
Operational model
IT requirements

Structure Three Inter-Related Processes Running in Parallel



Necessary ACO/CIO Infrastructure



Selection of Management Services Organization(s)

- Identify vendors
- RFP process to evaluate capabilities
- Selection of MSO(s) for CIO/ACO

ACO Success Tied to Key CMS Performance Metrics

BETTER CARE FOR INDIVIDUALS

- ☑ Preventative Health
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- ☑ At Risk Population: Hypertension
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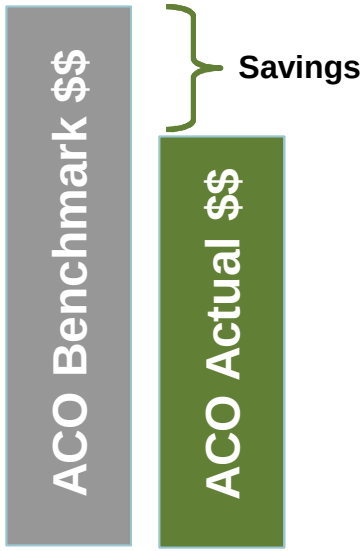
BETTER CARE FOR POPULATIONS

MSSP Incentive Award Opportunity

Expenditure Reduction Achieved by ACO × **50%** × **Performance Score Earned by ACO** = **MSSP Shared Savings Award Paid to ACO**



- Part A and Part B claims for beneficiaries attributed to the ACO
- Benchmark projection based on 3 years of CMS data

Patient/Caregiver Experience (7 metrics)

☑☑☑☑☑☑☑

Care Coordination Patient Safety (6)

☑☑☑☑☑☑

Preventative Health (8)

☑☑☑☑☑☑☑☑

Managing At-Risk Populations (12)

☑☑☑☑☑☑☑☑
☑☑☑☑☑☑

33 Total Performance Metrics

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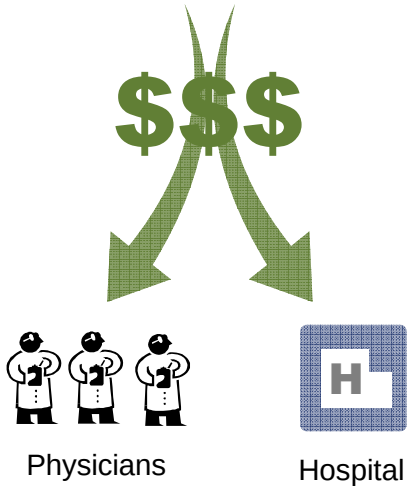
ACO Portion of Shared Savings



- Total award is capped at 10% of Benchmark expenditures
- Calculation of award occurs 4-6 months after end of year.

ACO Infrastructure Gap Analysis

☐ Acceptable ☐ Needs Some Development ☐ Needs Significant Development

Structure and Governance		Comments
1) Strong ACO leadership team	☐	No designated leader for ACO as yet (no internal candidate with strong leadership skills yet identified. Need names for application.
2) Strong clinical leadership	☐	No designated leader as yet; significant structural challenges with current PCPs
3) Support ACO participant in other locations	☐	Current planning only focused on RWHS resources, but realistically, ACO will need to enlist other independent service providers to expand network coverage and tracking
4) Analyze, negotiate and manage multiple product offerings	☐	Not possible with current systems. Need to develop more targeted IT infrastructure to support SCO scale-up

Quality Management and Innovation		
1) Perform patient stratification and predictive modeling	☐	Not possible with current systems. Need to identify outside vendor to support needed functionality
2) Track medical resource use (inpatient and outpatient)	☐	Partial reporting possible with existing financial systems assessing RWHS services. Integration of outside ACO providers not possible at this time.
3) Perform provider profiling	☐	Limited provider profiling in place. Not tied specifically to ACO metrics.
4) Medication reconciliation	☐	Is done but not captured by all providers in NextGen
5) Track MSSP ACO metrics	☐	NextGen has capability to track majority of required reporting metrics; however, will require more complete use of system by physicians
6) Focus on continuous innovation and opportunities for quality improvement	☐	Difficult to achieve due to extremely limited quality tracking and improvement experience within RWPC

ACO Infrastructure Gap Analysis

☐ Acceptable ☐ Needs Some Development ☐ Needs Significant Development

		Comments
Patient Engagement		
1) Attribute and track patients to PCP	☐	Unable to track in NextGen at this time. Could potentially set up special fields to track
2) Communicate (and track communication) with patients in a variety of ways	☐	Limited to phone calls, and phone tree messaging. There is a field in NextGen to capture some member communication but it is inactive.
3) Availability and promotion of patient education resources	☐	Limited staff and printed material resources
4) Patient-directed care initiatives	☐	Not present. Preliminary evaluation of potential development of a new stand-alone member portal. Lowest bid was $850K
Care Transformation Support		
1) Plan and implement disease management programs	☐	Not present in current clinical model. Will need outside support to implement and monitor. Needs to tie to medical home development and implementation of disease registries
2) Manage care across care settings and transitions	☐	Basic discharge planning in place but other transitions (e.g., ER admissions, SNF-related, etc.) not developed or staffed
3) Use process improvement focused on a system-wide care model	☐	Very limited capabilities, primarily focused on hospital. Need to undertake significant effort to build quality and medical management models and track key processes.
4) Defined processes for peer review and teamwork	☐	Need to develop new processes based on ACO quality requirements. The current environment does not support decisive peer review and performance/behavior management.

ACO Infrastructure Summary

☐ Acceptable ☐ Needs Some Development ☐ Needs Significant Development

Information Continuity and Management		Comments
1) Provide integrated view of patient information to providers	☐	Not all department or providers use EHR. Paper records in different formats are still in use. SNF on separate system; not integrated. Limited patient data available through statewide HIE.
2) Smooth and consistent provider to provider communication	☐	Limited due to uneven EHR use among physicians at this time
3) Easy access to clinical protocols and pathways	☐	IP protocols in place; no OP protocols are available. Need to develop policies and procedure to adopt and Implement new protocols.
4) Health information exchange abilities with suppliers and outside providers	☐	Near time submission of certain data. Lab is real time. Problems with timely dictations.
4) Decision support and reporting analytics to assist performance tracking	☐	Partial capability through NextGen; need vendor or contractor

Finance Analysis and Reporting		
1) Track and report on key performance benchmarks	☐	Majority of performance metrics active (or could be activated) in NextGen
2) Track and report on ACO budgets, utilization and other key financial parameters	☐	Internal capability needs to be developed
3) Ability to load encounter data for analysis and reporting	☐	Potential capability through RWHS TPA organization; needs further evaluation
4) Support multiple reimbursement arrangements	☐	No current capability; needs to be developed

ACO Infrastructure Gap Analysis

☐ Acceptable ☐ Needs Some Development ☐ Needs Significant Development

Operations Support		Comments
1) Ability to pay care management fees	☐	Not currently available
2) Portal access for providers	☐	Providers can access IP data
4) Portal access for patients	☐	Not currently available. Need to prioritize development of selected functionality (online physician communication; scheduling; results)
5) Call center capabilities	☐	Not currently available. Need to prioritize to expedite access to resources for ACO participants

Network Development and Support		
1) Track ACO participants, providers and suppliers	☐	Limited capability to track providers within RWHS. Unable to track utilization of ACO service providers outside RWHS.
2) Analyze adequacy of ACO's participants' network coverage	☐	Not currently available
3) Support provider enrollment in other ACO products outside of MSSP	☐	Not currently available

MSSP Quality Measures: Better Care for Individuals

☐ Acceptable ☐ Needs Some Development ☐ Needs Significant Development

☑ Patient / Caregiver Experience

Measurement	Method of Submission		Findings/Comments
CAPHS: Getting Timely Care, Appointments, and Information	Survey	☐	Captured by outside vendor
CAPHS: How well your Doctor's Communicate	Survey	☐	Captured by outside vendor
CAPHS: Patient Rating of Doctor	Survey	☐	Captured by outside vendor
CAPHS: Access to Specialists	Survey	☐	Captured by outside vendor
CAPHS: Health Promotion and Education	Survey	☐	Captured by outside vendor
CAPHS: Shared Decision Making	Survey	☐	Captured by outside vendor
CAPHS Health Status/Functional Status	Survey	☐	Captured by outside vendor

MSSP Quality Measures: Better Care for Individuals

☐ Acceptable ☐ Needs Some Development ☐ Needs Significant Development

☑ Care Coordination / Patient Safety

Measurement	Method of Submission		Findings/Comments
Risk-standardized, all condition readmission: the rate of readmissions within 30 days of discharge from an acute care hospital for assigned ACO beneficiary population	Claims	☐	Will required additional data collection and analytics to ensure timely tracking (rather than waiting for CMS reports)
Ambulatory sensitive conditions admissions: chronic obstructive pulmonary disease [Findings/Comments prevention quality indicator (PQI) #5]	Claims	☐	Will required additional data collection and analytics to ensure timely tracking (rather than waiting for CMS reports)
Ambulatory sensitive conditions admissions: congestive heart failure [Findings/Comments prevention quality indicator (PQI) #8)	Claims	☐	Will required additional data collection and analytics to ensure timely tracking (rather than waiting for CMS report)
Percent of PCPs who successfully qualify for an EHR incentive program payment	EHR Incentive Program	☐	Need to complete NextGen implementation and meaningful use tracking
Medication reconciliation after discharge from an inpatient facility	GPRO Web Interface	☐	Now done by case managers. Ability to track and analyze for Medicare patients specifically needs to be assessed
Falls: screening for fall risk	GPRO Web Interface	☐	Not currently used. Could be implemented in NextGen

MSSP Quality Measures: Better Care for Populations

☐ Acceptable ☐ Needs Some Development ☐ Needs Significant Development

☑ Preventive Health

Measurement	Method of Submission		Findings/Comments
Influenza immunization	GPRO Web Interface	☐	Captured in NextGen
Pneumococcal vaccination	GPRO Web Interface	☐	Captured in NextGen
Adult weight screening/ follow up	GPRO Web Interface	☐	Captured in NextGen; however, some clinics do not measure height needed to calculate BMI
Tobacco use assessment and cessation intervention	GPRO Web Interface	☐	In place as soon as rollout to PCP clinics is complete
Depression screening	GPRO Web Interface	☐	Available in NextGen; however, screening tools are deep in system and hard to access
Colorectal cancer screening	GPRO Web Interface	☐	Captured in NextGen
Mammography screening	GPRO Web Interface	☐	Captured in NextGen
Proportion of adults who had blood pressure measured within preceding 2 years	GPRO Web Interface	☐	Captured in NextGen

MSSP Quality Measures: Better Care for Populations

☐ Acceptable ☐ Needs Some Development ☐ Needs Significant Development

☑ At Risk Population: Diabetes

Measurement	Method of Submission		Findings/Comments
Diabetes composite hemoglobin a1c control (<8 percent)	GPRO Web Interface	☐	Captured in NextGen
Diabetes composite LDL (<100)	GPRO Web Interface	☐	Captured in NextGen
Diabetes composite: blood pressure <140/90	GPRO Web Interface	☐	Captured in NextGen
Diabetes composite: tobacco non use	GPRO Web Interface	☐	Not in system
Diabetes composite: aspirin use	GPRO Web Interface	☐	Captured in NextGen
Diabetes mellitus: hemoglobin A1c poor control (>9 percent)	GPRO Web Interface	☐	Captured in NextGen

☑ At Risk Population: Hypertension

Measurement	Method of Submission		Findings/Comments
Percent of patient visits for with a diagnosis of HTN with either systolic blood pressure ≥140 mmHg or diastolic blood pressure ≥ 90 mmHg with documented plan of care for hypertension	GPRO Web Interface	☐	Captured in NextGen

MSSP Quality Measures: Better Care for Populations

☐ Acceptable ☐ Needs Some Development ☐ Needs Significant Development

☑ At Risk Population: Ischemic Vascular Disease

Measurement	Method of Submission		Findings/Comments
IVD: Complete Lipid Profile and LDL Control <100 mg/d	GPRO Web Interface	☐	Captured in NextGen
IVD: Use of Aspirin or another anti-thrombic	GPRO Web Interface	☐	Not in system

☑ At Risk Population: Heart Failure

Measurement	Method of Submission		Findings/Comments
Beta Blocker Therapy for Left Ventricular Systolic Dysfunction	GPRO Web Interface	☐	Captured in NextGen

☑ At Risk Population: Coronary Artery Disease

Measurement	Method of Submission		Findings/Comments
CAD Composite: Drug therapy for lowering LDL cholesterol	GPRO Web Interface	☐	Captured in NextGen
ACE Inhibitor or ARB therapy for patients with diabetes or left ventricular systolic dysfunction (LVSD)	GPRO Web Interface	☐	Captured in NextGen

MSSP Incentive Award Opportunity

Expenditure Reduction Achieved by ACO × **Performance Score Earned by ACO** = **MSSP Shared Savings Award Paid to ACO**

- Part A and Part B claims for beneficiaries attributed to the ACO
- Benchmark projection based on 3 years of CMS data

Patient/Caregiver Experience

☑☑☑☑☑☑☑

Preventative Health

☑☑☑☑☑☑☑

Care Coordination Patient Safety

☑☑☑☑☑☑

Managing At-Risk Populations

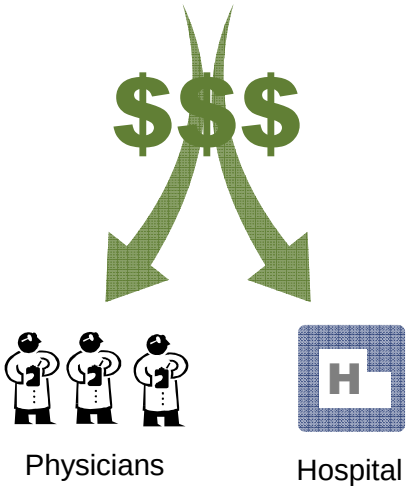
☑☑☑☑☑☑☑

☑☑☑☑☑☑

33 Total Performance Metrics

- In Year 1, requirement is complete and accurate reporting on all measures
- In Years 2 and 3, a performance score is calculated for the ACO

ACO Portion of Shared Savings



- Total award is capped at 10% of Benchmark expenditures
- Calculation of award occurs 4-6 months after end of year.

ACO – Illustration of Potential MSSP Funds Flow

		Enrollment	Per Member Per Month	Aggregate Annual	Physicians' Share
Enrollment		5,000			
Medicare FFS Part A and Part B			$1,000	$60,000,000	
Total Savings:	20%		$200	$12,000,000	
Max Shared Savings:	50%		$100	$6,000,000	
Actual Shared Savings Performance Score:	100%		$100	$6,000,000	
Care Management Fee			$10	$600,000	$600,000
Administration Infrastructure Fee			$15	$900,000	
Net Savings			**$75**	**$4,500,000**	**$2,250,000**

V1

Performance Score Determines % of Incentive Award

- **Year 1:** ACOs must completely and accurately report on all 33 required quality measures.
- **Year 2**: ACOs must meet a minimum quality standard (30th percentile of the national Medicare quality performance rates) in 70% of the required measures in each of the 4 quality domains (25 measures total for Year 2).
  - ACOs must report completely and accurately on 100% of the remaining 8 measures.
- **Year 3**: ACOs must meet a minimum quality standard (30th percentile of the national Medicare quality performance rates) in 70% of each of the 4 quality domains (32 total.)
  - ACOs must accurately and completely report one measure (CAHPS Health/Functional Status).

Clinical quality scores and demonstrated reporting → **Weighted average CMS formula generates total score for ACO** → **Score determines % of achieved shared savings that will be paid to ACO**

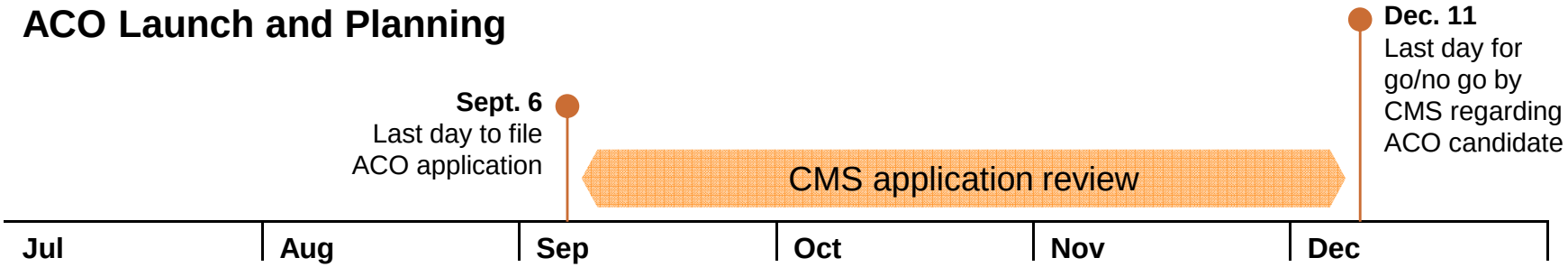
Application Summary

Ten page document divided into twelve sections

- Contact information
- General ACO Organization information
- Indication of “Newly Formed” Status
- Legal requirements
- ACO governance
- ACO leadership and management
- Participation in other CMS shared savings programs
- Management of shared savings
- ACO participant information
- Data sharing
- Required clinical processes and patient centeredness
- Certification

Timeline and Priorities through 2012

Remainder 2012
ACO Launch and Planning



- Organization of ACO Board and committees
- Recruitment of PCPs
- Obtain signed Provider Participation Agreements
- Completion of CMS ACO application
- Selection of MSO(s).
- Initial modeling to determine investment and potential returns

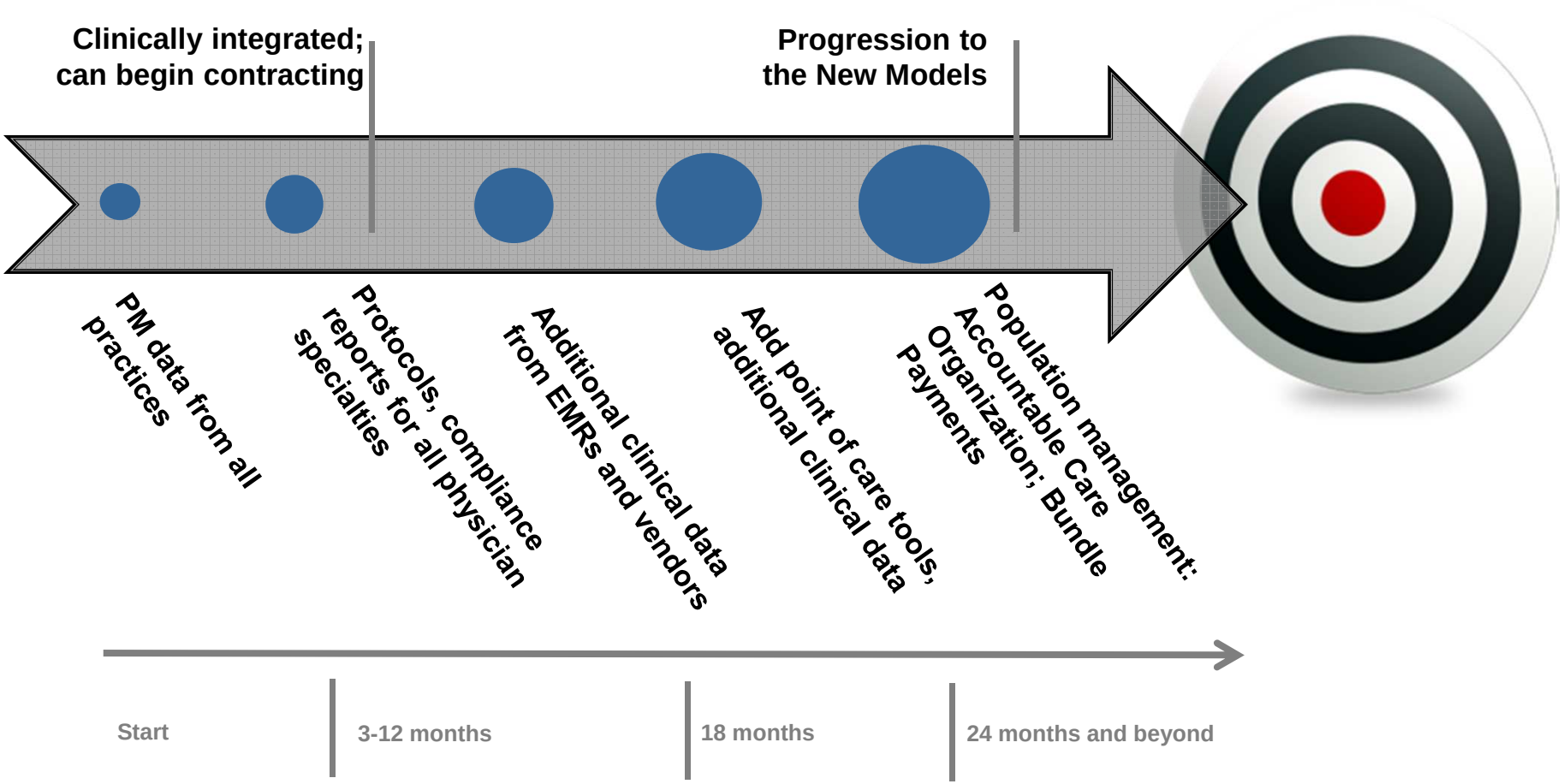
- Responding to CMS queries regarding application
- Working with CMS to incorporate beneficiary assignments
- Working with MSO(s) to prepare for data collection, reporting and other infrastructure requirements
- Ensure ability to report accurately on 33 performance metrics for 2013
- Work on transformation of care management model
- Assess priorities for managing population and reducing cost of care
- Prepare for “go-live” operations January 1, 2013.

ACO/CIO Continues to Mature over Time

- Intensive focus on achieving effective connectivity and data sharing between ACO participants (connectivity has special “weight” in compensation formula)
- Accelerate development of medical home models with special focus on managing specific at-risk populations targeted in CMS metrics
- Work with MSO(s) to ensure timely and effective reporting and tracking of utilization
- Develop, promulgate and educate providers on performance tools and tracking
- Determine gaps in clinical and support services and backfill as needed
- Advance discussions with commercial payers regarding value-based purchasing
- Explore changes needed to achieve FTC-compliant clinical integration, and evaluate changes needed for entity to contract as CIO

- Develop and implement appropriate strategies to improve operations based on 2013 clinical and financial performance
- Focus on care management strategies to ensure that maximum shared savings is achieved.
- Continue to advance provider connectivity and utilization of online data, reports and alerts
- Move forward with commercial VB contracts

ClOs/ACOs Clinical/Business Model Timing Evolution



Traditional PHO vs. CIOs/ACOs

Previous PHOs		MSSP ACO
Ineffective utilization management	→	Appropriate utilization (and demonstrated quality) by providers
Capitation and withholds	→	FFS plus incentives
Full risk contracts at outset	→	Increasing risk as CIO matures
Payer-centric leadership	→	Physician and provider led
Limited technology support	→	Widely-shared technology infrastructure
No active care management	→	Care management, including chronic disease

KEY TAKEAWAYS

- ☑ **ACO planning/development will involve representative physician leadership and input from the outset**
- ☑ **Opportunity for physicians to organize themselves for participation in CIO governance and management structure**
- ☑ **Clinical integration strategy is physician-driven**

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Appendix
– Core Governmental/ Commercial Payer Strategies for CIOs

SSB Solutions

Core Payer Strategies Support CIO Development

Recurrent Themes from Governmental Entities such as State Medicaid Programs and State Employee Programs (Plug and Play)

States are looking closely at programs and benefit structures to evaluate whether state funds go to Health Plans or Delivery System CIOs. Such as :

- Texas incentivizing the aggregation of multiple rural hospitals to form a 14 hospital CIO to contract for Texas Medicaid and Dual Eligible Beneficiaries;
- New York Medicaid going to a “North Shore Long Island Hospital/ValueOptions” partnership for coordinated mental health benefits;
- Arizona looking at Super CIOs consisting of Multiple Health System CIOs coming together to form an entity to compete against health plans or larger delivery system CIO competition & ACO participation agreements; and
- Nebraska contracting with United Health Plans for State employees at the expense of BCBS of Nebraska and exploring specialty population pilots.

Core Payer Strategies Support CIO Development

Recurrent Themes from Large For Profit Health Plans

- United, Humana, Aetna, and Cigna are launching or will launch “Value-Based Plans”(VPNs) starting with existing core products: 1) ASO Employer Plans (CIGNA), 2) Medicare Plans (Humana, United); 3) Small, Mid Size and Large Group Employer Plans (United, Aetna, etc.); 4) Individual Market/State Exchanges (United, Aetna, Cigna, Humana, etc.) and Medicaid (United, Aetna, Cigna, Humana). All want dual eligibles due to their high cost. Select companies want Medicaid.

- Every major plan views VBPs as creating a lower price point option and very attractive to the employer/governmental payer in an environment with or without a formal retail (Exchange) market.

- Virtually all for profit plans see VBPs leading to more at risk or % of premium contracting with narrower networks.

- Health plans will employ/buy providers of all types especially PCPs/IPAs/POs.

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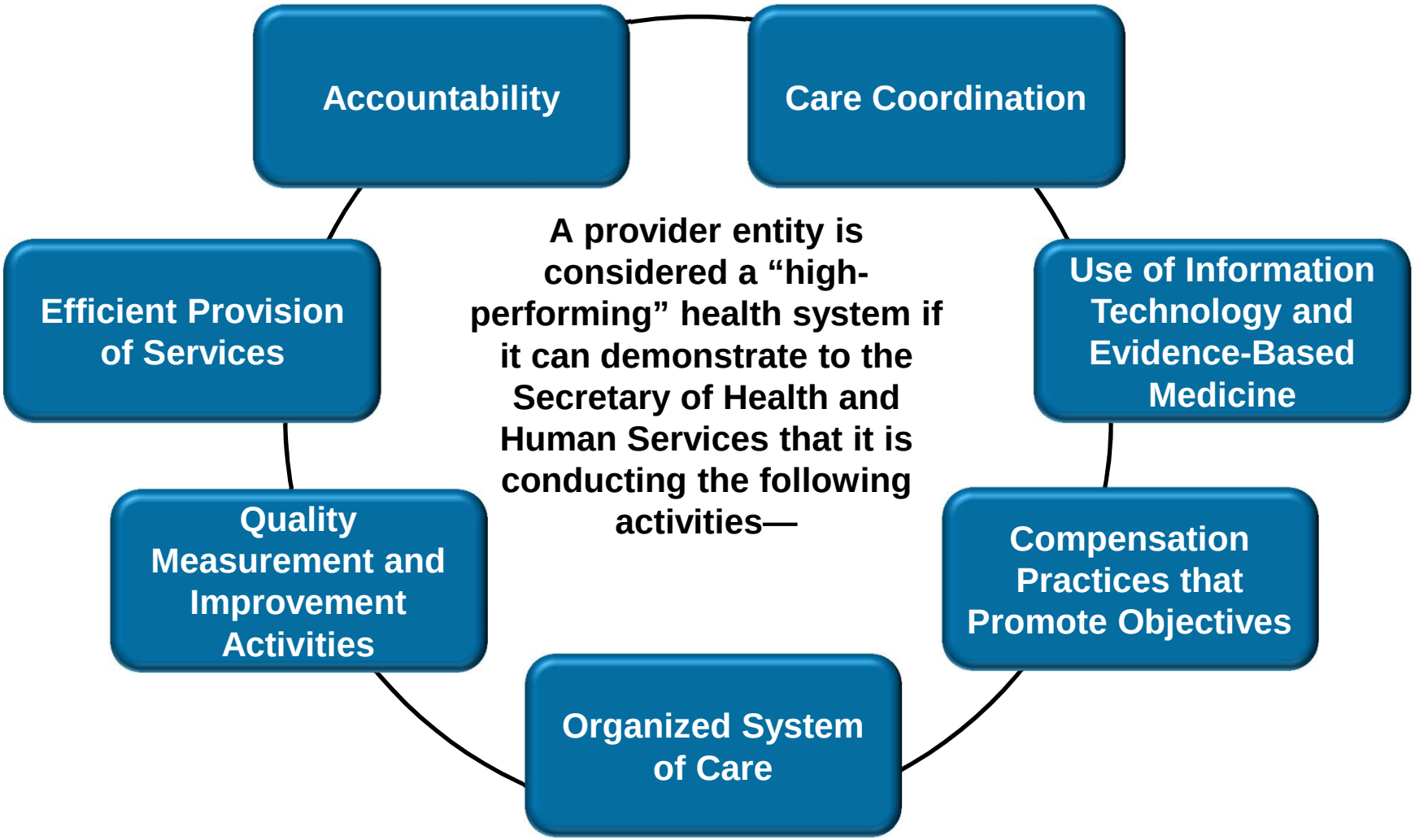
Appendix
– AMGA "High-Performing" Health System

SSB Solutions

AMGA "High-Performing" Health System – Key Elements



A Provider Entity is Considered a "High-Performing" Health System if it can Demonstrate to the Secretary of Health and Human Services that it is Conducting the Following Activities — Proposed AMGA Language

A. Efficient provision of services: The provider entity successfully manages the per capita cost of health care, and improves—

- *the overall patient care experience, and*
- *the health of their respective populations..*

B. Organized System of Care: The provider entity includes a multi-specialty medical group or other organized system of care and—

- *Provides a continuum of care, including prevention and ambulatory care, for a population of patients;*
- *Is integrated or has partnerships with other care sites, which may include, but not be limited to, acute care hospitals, long-term acute care hospitals, inpatient rehabilitation facilities, skilled nursing facilities, home health agencies, ambulatory surgery centers, and hospices to provide the appropriate care setting for each patient's needs;*
- *Includes physicians who are the principal leaders of all clinical programs and medical care and share responsibilities for the non-clinical aspects of governance, administration and management; and*
- *Assumes accountability for coordination across transitions in care.*

A Provider Entity is Considered a "High-Performing" Health System if it can Demonstrate to the Secretary of Health and Human Services that it is Conducting the Following Activities — Proposed AMGA Language

C. <u>Quality measurement and improvement activities:</u> The provider entity conducts quality measurement and improvement activities across sites of care and between patient visits to improve the health and outcomes of populations, including:

- *Preventive care and chronic disease management for targeted groups of patients;*
- *On-going patient outreach programs, such as patient registries, to improve the health of those populations;*
- *Participation in continuous learning, such as collaboratives, and the conduct of benchmarking on utilization rates and patient outcomes with other peer groups;*
- *Use of research and/or other mechanisms, such as applied data analytics, to validate clinical process and outcomes data to determine effectiveness;*
- *External reporting and transparent internal reporting on clinical outcomes, variability, and timely performance improvements; and*
- *The conduct of patient experience surveys which would be made publicly available.*

A Provider Entity is Considered a "High-Performing" Health System if it can Demonstrate to the Secretary of Health and Human Services that it is Conducting the Following Activities — Proposed AMGA Language

D. **Care coordination**: The provider entity uses a team-based approach that supports collaboration and communication among the patient, physician, and licensed or certified medical professionals who are working at the top of their field across medical specialties and health care settings to improve the patient's well-being. This activity shall include:

- *A single plan of care across health care settings and across health care providers who furnish care to the patient; and*
- *Shared decision making—*
  - *Which—*
    - *Is a collaboration between the patient and health care provider that empowers the patient in the decision making process; and*
    - *Provides the patient with objective information concerning—*
      a) *The risk or seriousness of the disease or condition to be prevented or treated;*
      b) *Available treatment alternatives; and*
      c) *The costs and benefits of available treatment alternatives.*

A Provider Entity is Considered a "High-Performing" Health System if it can Demonstrate to the Secretary of Health and Human Services that it is Conducting the Following Activities — Proposed AMGA Language

E. **Use of information technology and evidence-based medicine:** The provider entity meaningfully uses interoperable information technology, scientific evidence, and comparative analytics to:

- *Aid in clinical decision making and improve patient safety;*
- *Help monitor patients and track preventive services; and*
- *Aid in the prescribing of prescription drugs.*

F. **Compensation practices that promote the above-listed objectives:** The provider entity uses compensation structures that provide incentives to physicians and licensed and certified medical professionals to improve the health and outcomes of populations. These compensation practices may include, but not be limited to, incentives that are affiliated with:

- *Patient experience; or*
- *Quality metrics, such as chronic disease measures and prevention compliance within a physician's managed population.*

G. **Accountability:** The provider entity assumes shared financial and regulatory responsibility and accountability for successfully managing the per capita cost of health care, improving the overall patient experience, and improving the health of their respective populations.