“The Crescent PPO Experience”

Building an Accountable Care Organization
for
Western North Carolina

“Bottom Up”

or

“Top Down”

???

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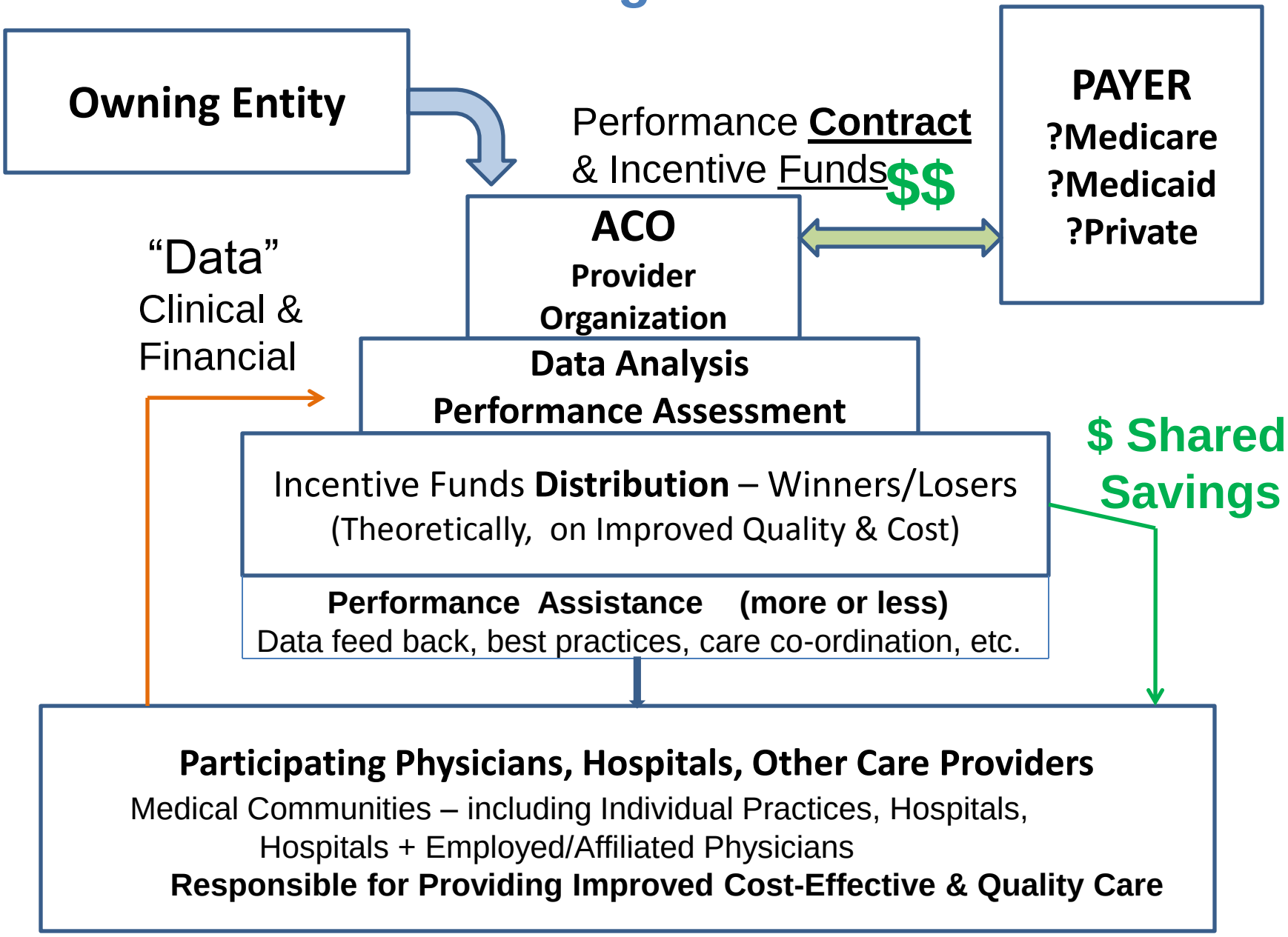
Accountable Care Organization "Basics"

- ACOs are increasingly seen as an answer to unsustainable increases in Health Care costs
- ACOs will likely transform the System of Health Care Delivery in the US
- ACOs will likely change relationships: Payers vs Providers vs Providers
- ACOs are Provider Organizations that a Payer contracts with to provide care for a defined population.
  If the ACO meets "cost and quality contractual requirements", the ACO gets a "financial reward" that it "shares" with ACO participants [with "the devil" in the details]
- Payers like ACOs – They transfer liability for quality and cost control, along with politically difficult decisions, to Providers
- Providers (esp. large Regional Health Systems) like ACOs – They allow their "system owned ACO" to control the health care management, control performance data analysis, control money flow, and control care access in a region

Accountable Care Organization Structure



ACO Performance

Quality and Cost-Effectiveness Improvements

Ultimately Achieved at the Individual Provider Level

(How to get everyone on board?)

Strategic Goals may include:

- Better co-ordination of care
- Better chronic disease management
- Reduce unnecessary admissions
- Accurate, cost efficient diagnosis
- Most cost effective therapeutics
- Stimulate healthier lifestyles

Tools could include:

- Clinical data analysis and "feedback"
- Support best practice guidelines
- Patient Centered Medical Homes
- Systematic care coordination
- Well structured and fair incentives
- Public support for healthier living

True Test of an ACO / The Bottom Line: Outcomes

How well the ACO can encourage and support individual physicians, hospitals, and medical communities to reach Dr. Don Berwick's "Triple Aim" of:

1) Better Care – Better Quality and Better Cost-Effectiveness
2) Healthier Communities – With Reduction in Preventable Disease
3) Better Costs – With Reduced Per Capita Expenditures

ACO Organizational Structure Design

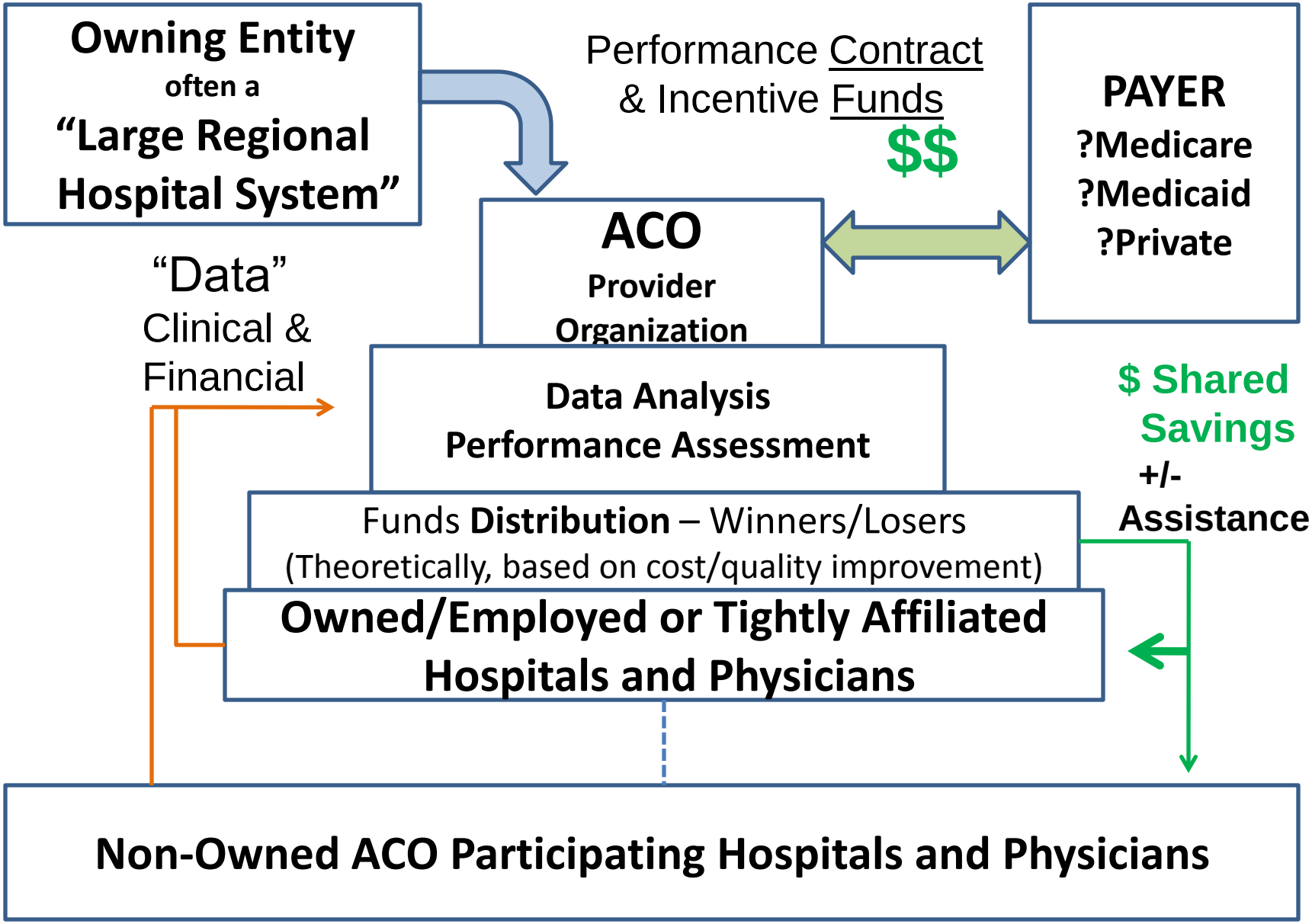
Hopefully, ACOs will be designed for
improvement of health care and to benefit patients

But sometimes there is the tendency to design around
Power, Control, and the Flow of Money

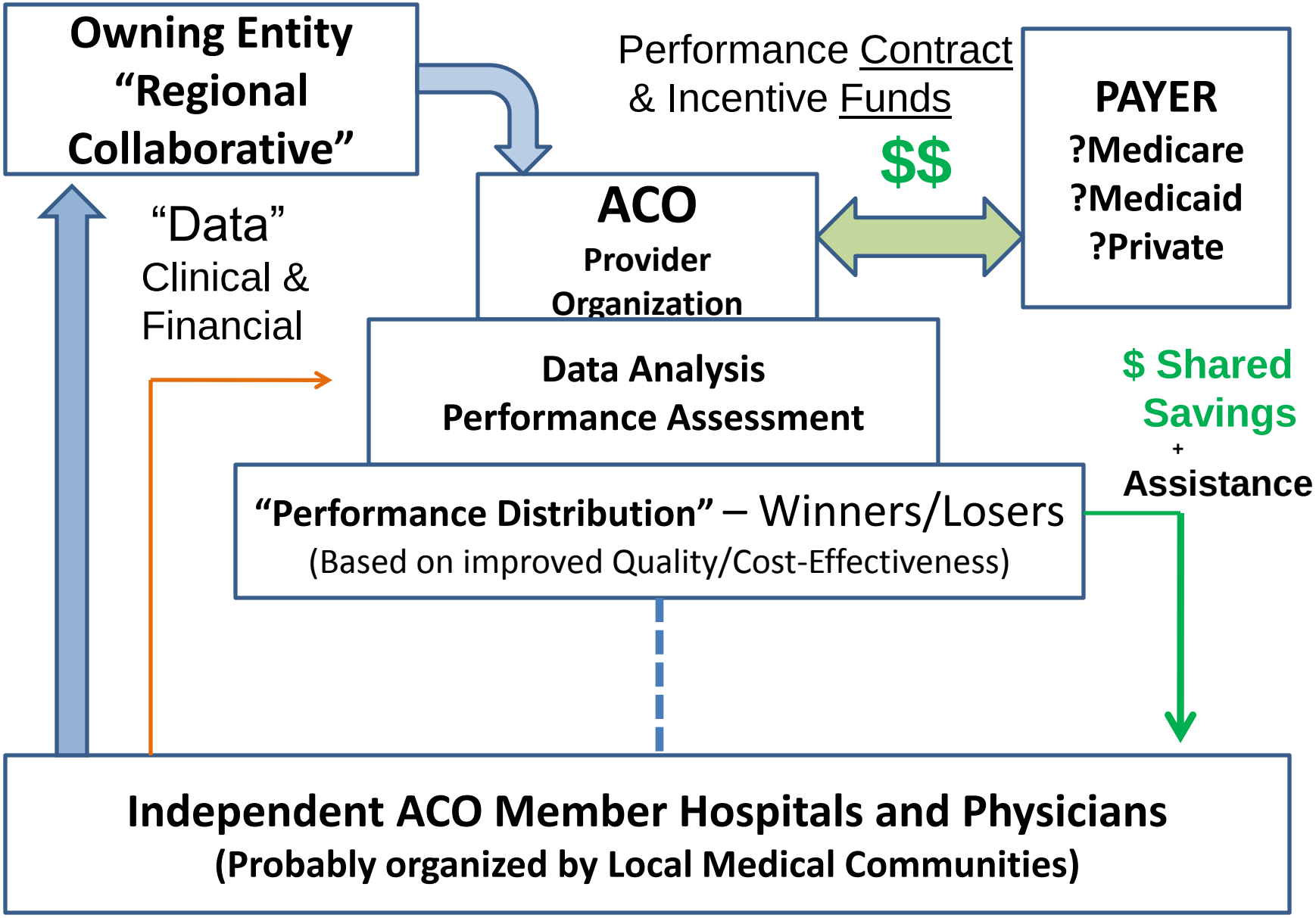
So Ask:

Who Owns the ACO ?
Who Benefits from the ACO Structure?
Who Controls the ACO-Payer Contract ?
Who Controls Data & Performance Analysis ?
Who Controls “Shared Savings” Distribution?
Who Controls Provider Participation in the ACO?
How Are Participating Physicians and Hospitals
Involved in ACO Decisions?

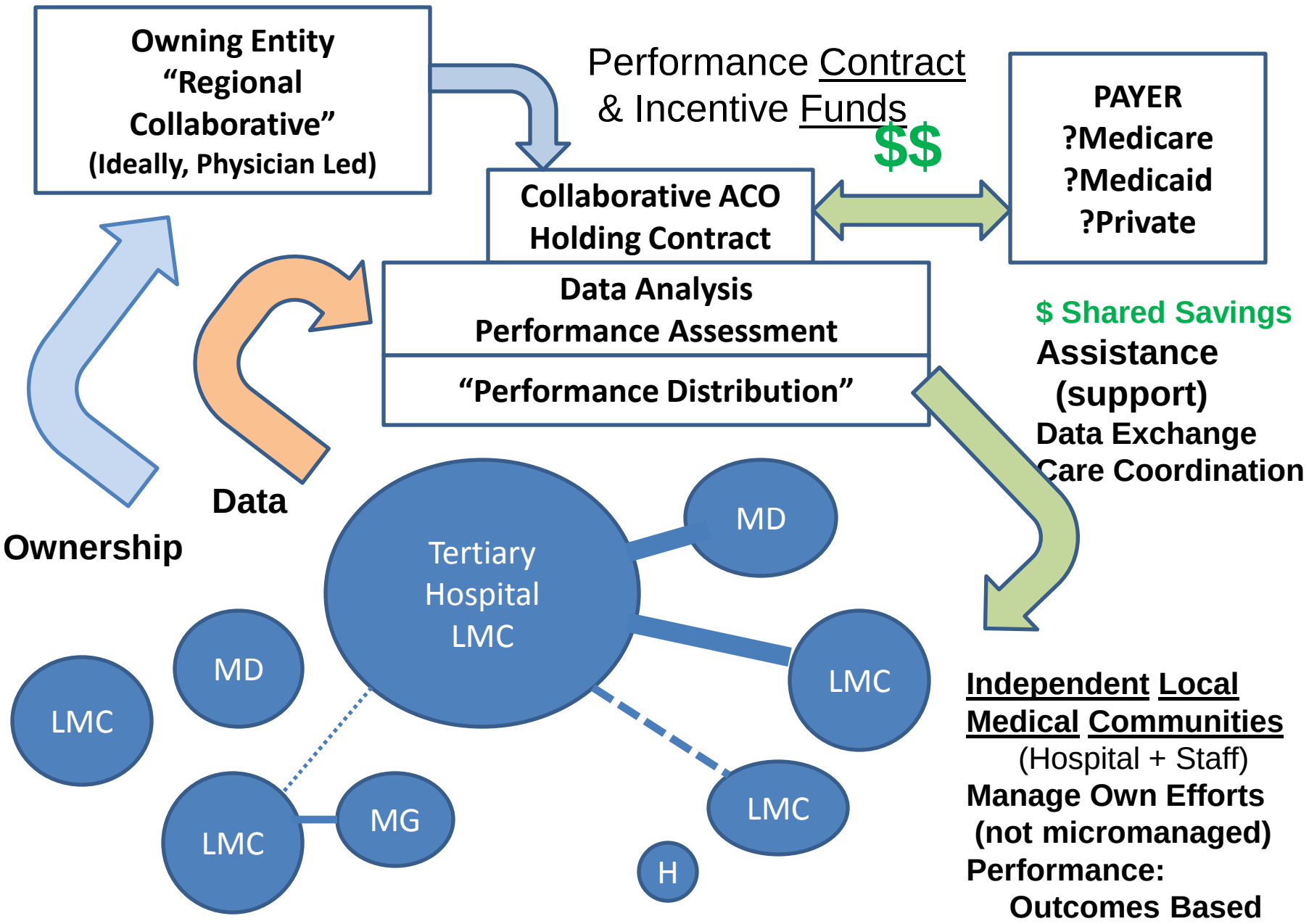
"TOP DOWN" ACO


Owning Entity
often a
"Large Regional Hospital System"
Performance Contract & Incentive Funds
$$
PAYER
?Medicare
?Medicaid
?Private
ACO
Provider Organization
"Data"
Clinical & Financial
Data Analysis
Performance Assessment
$ Shared Savings
+/-
Assistance
Funds Distribution – Winners/Losers
(Theoretically, based on cost/quality improvement)
Owned/Employed or Tightly Affiliated Hospitals and Physicians
Non-Owned ACO Participating Hospitals and Physicians

"BOTTOM UP" ACO



"BOTTOM UP" ACO



ACO Performance

Quality and Cost-Effectiveness Improvements

Ultimately Achieved at the Individual Provider Level

(Getting All On Board with a Common Vision and Effort)

"<u>Top Down ACO</u>"

more likely

Controlling

Micromanaging

Reduced "Buy In" with possibly less productive effort

Monopoly - One Controls all; so Limited options

<u>But</u>, easier to manage; more predictable

<u>Strategic Goals include</u>:

- Better co-ordination of care
- Better chronic disease management
- Reduce unnecessary admissions
- Accurate, cost efficient diagnosis
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- Stimulate healthier lifestyles

<u>Tools can include</u>:

- Clinical data analysis &"feedback"
- Support guidelines & best practices
- Patient Centered Medical Homes
- Systematic care coordination
- Well structured and fair incentives
- Public support for healthier living

"<u>Bottom Up ACO</u>"

more likely

Collaborative

Macromanaged

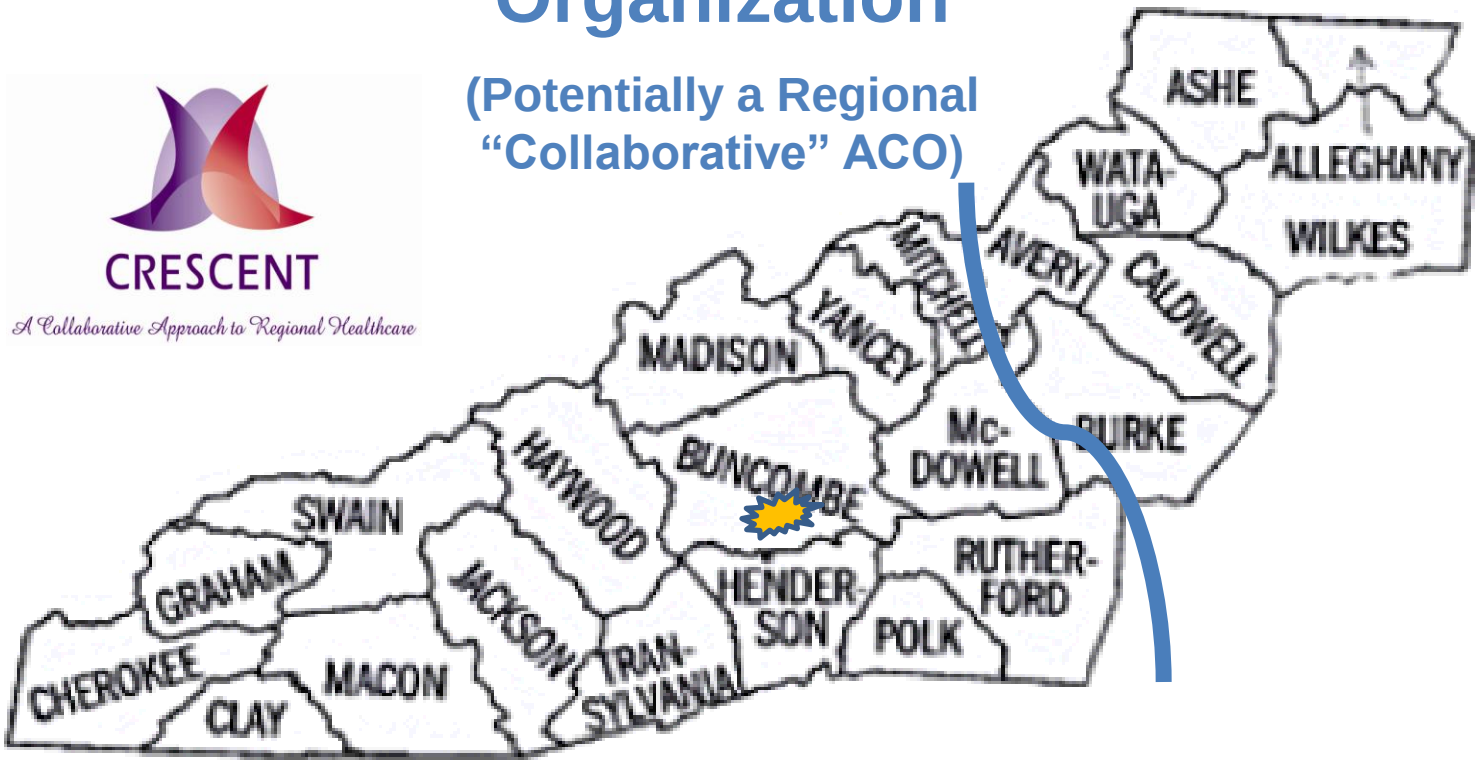
Better "Buy In" with possibly more productive results

Independent communities with Provider options

<u>But,</u> harder to manage; and less predictable

Crescent PPO, Inc Organization

(Potentially a Regional "Collaborative" ACO)



Non-Profit "Messenger Model" PPO; Includes most Physicians & Hospitals of WNC

Formed in 1999, when leaders of IPAs, PHOs & Hospitals of WNC came together

Board - 10 Physicians, 5 Hosp. reps, 2 Employer reps – from across WNC

Covers 16 Western NC Counties – Pop. ~ 750,000

15 Hospitals, including 740 bed tertiary Mission Hospital

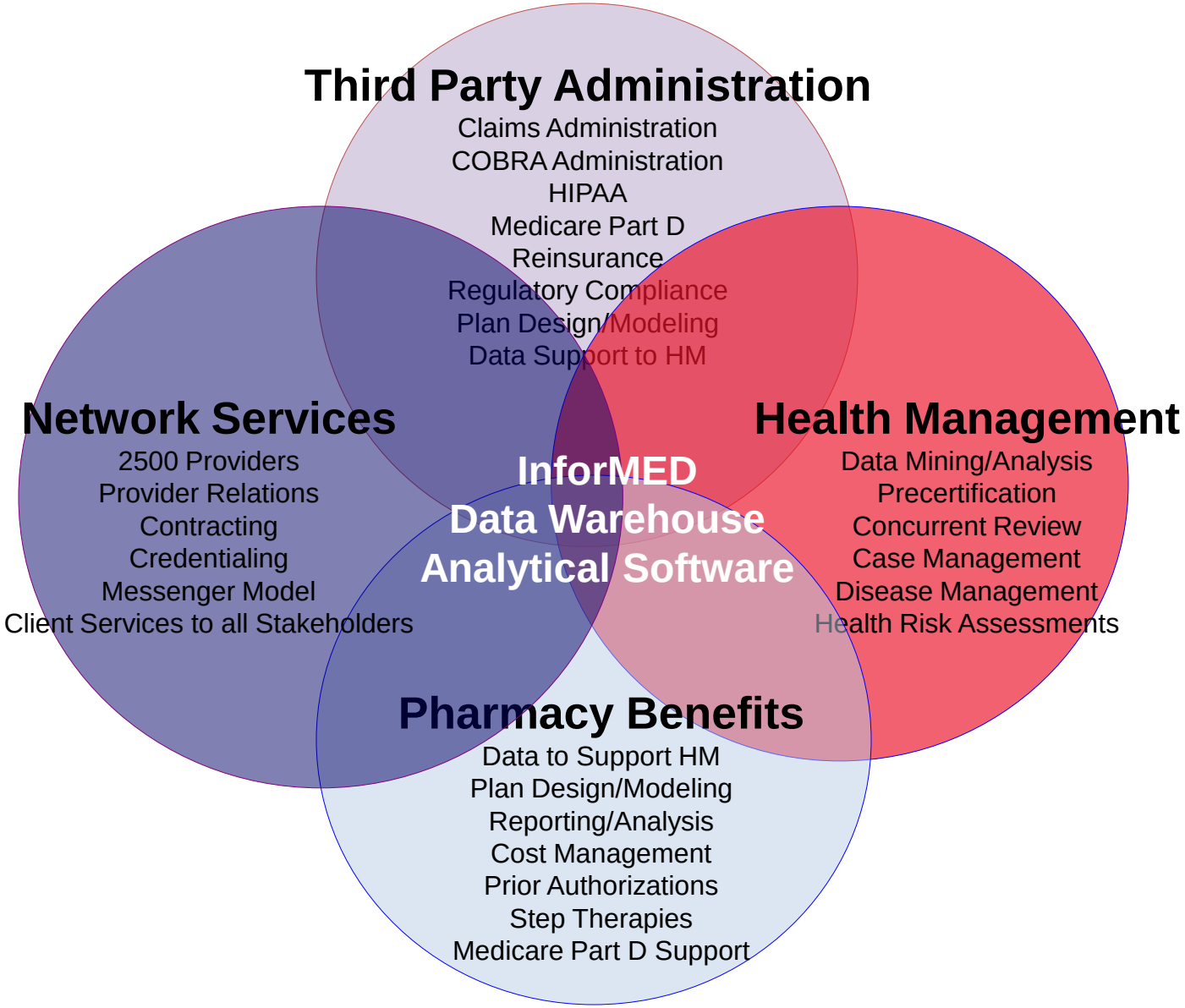
1,900 Physicians – all specialties

Covers many Employer Plans of WNC, about 36,000 covered lives

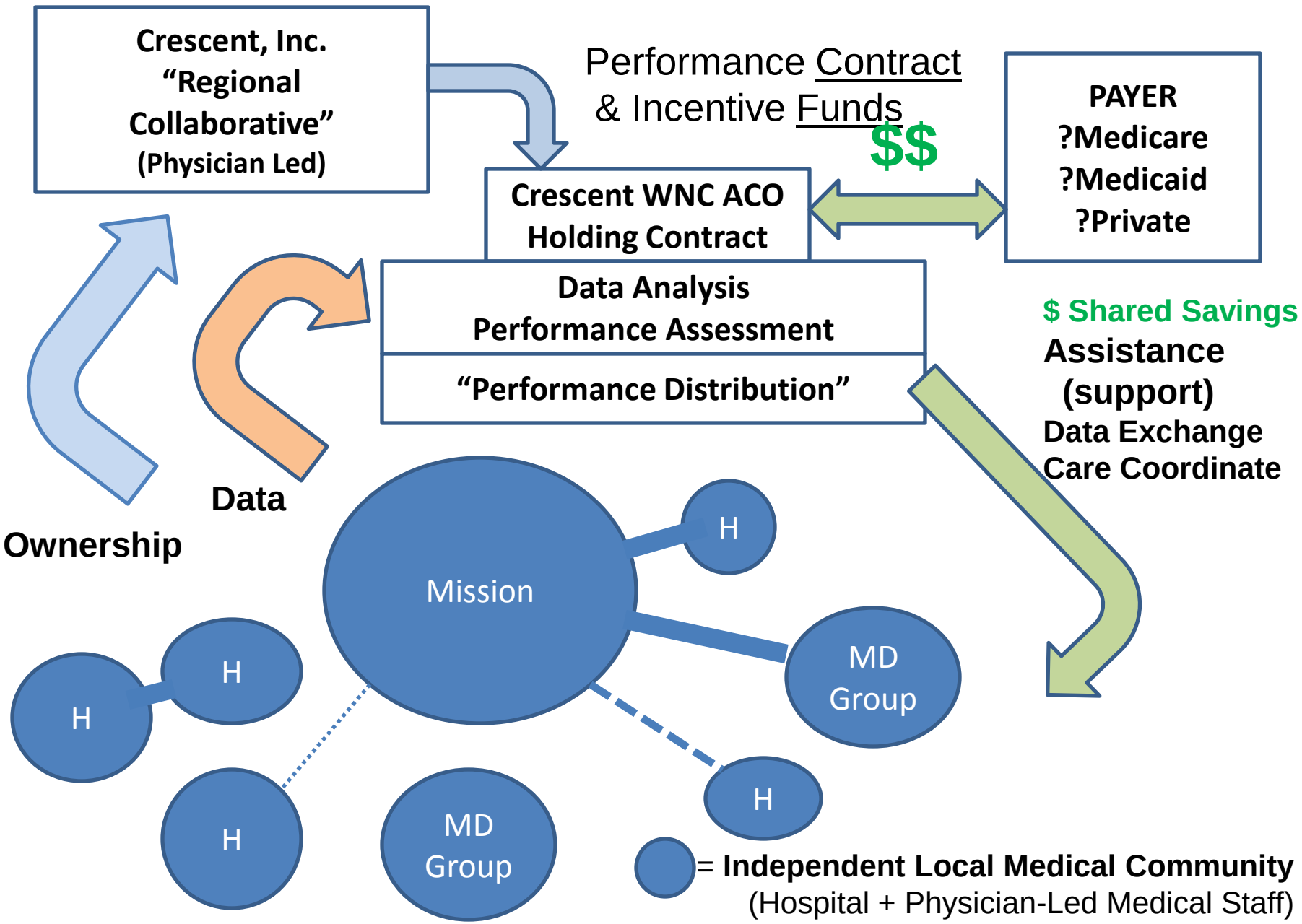
Crescent Positioned to become an ACO for WNC
("Bottom Up" Collaborative Type)

- Collaboratively owned by Physicians & Hospital Providers of WNC
- Physician led, but Partnership from Hospitals and Employers of WNC
- Core organizational infrastructure in place for an ACO
- Reputation for Competence, Fairness, Neutrality, Collegiality, and Collaboration with WNC Providers – able to serve as a trusted party for Data Analysis & Distribution of "Shared Savings"
- Able to support Local Medical Communities (Hospital & Physicians)
- Has administrative, contracting, and medical management expertise
- Has "third party administrative capability" – owns a TPA
- Affiliated Health Information Exchange (HIE) capability with Data Link; presently a hospital data exchange, plans to broaden capability
- Experience/Capability with Data Analysis and Performance Evaluation
- Experience/Capability with Case Management & Quality Improvement

Crescent Service Lines



Collaborative Crescent ACO



Challenges for Crescent Becoming a Regional ACO

- **Limited Capital and Administrative Staff in the Crescent Organization**
  - •However, only a "lean" organization needed; capital/capacity in LMCs
  - •Crescent's purpose: To provide coordination, not to micromanage.
  - •Some functions, ie. sophisticated data analysis, could be outsourced
- **How to provide a "Tight" Organization for ACO Payer Contracting**
  - •Presently, providers can choose limited time in particular PPO contracts, ACO contracting will require firm, longer term commitments
- **The Challenge of "Herding Cats" in a Collaborative Organization; and Getting all Providers to agree on Vision & How to Share Risk/Loss/Gain**
  - •Crescent has history of fair collaboration and collegial interactions
  - •Remind all: "Hang Together, or Hang Separately – and fracture WNC"
- **How to deal collaboratively with various health system "affiliations"**
  - •Affiliations include Mission Health System, Carolinas Health, Adventist
  - •A coherent WNC medical community in everyone's interest, esp. patients
- **Mission Health System intentions ? – a major Partner, or "The ACO"?**

Mission Health System's Consideration:

"Is it better to be the Major Partner in a Regional Collaborative ACO, or better to be 'THE' Regional ACO?" - Mission seems moving to the latter

- **Mission appears rapidly gearing up to become a Regional ACO for WNC**
- **Mission recently hired a new CEO**
  Ron Paulus, MD – presently VP for Operations/Innovations-Geisinger
  MD from U of Penn (with honors); MBA from Wharton (with honors)
  Founder and CEO (along with Dr. David Brailer) of CareScience,
  the HIT forerunner to the RHIO concept; sold to Premier, Inc.
- **Mission recently became part of the "Premier ACO Collaborative" Project**.
  Premier 's ACOC provides tools (data metrics, best practices, etc) and the sharing of ACO development concepts among large member Health Systems around the country (ie. Geisinger, Henry Ford, etc) – Thus, provides support for large health systems to build their "top down" ACOs.
- **Mission has several medical groups and hospitals in its Health System**
  and is closely affiliated with several other hospitals in WNC
- **Mission is holding a "Regional Conference" in the next few months**
  to try and bring WNC providers on board for a Mission led ACO
  (? a "pure top down" model or "federated collaborative top down" model)

So Where Are We with an ACO for Western North Carolina?

Crescent is actively exploring developing a "bottom up"
Collaborative ACO Model for WNC, built around Crescent PPO

Mission is actively exploring developing a "top down"
regional health system controlled ACO Model for WNC,
built around The Mission Health System

Mission is an outstanding health system, but will the providers of WNC be comfortable in a "top down" ACO model?

It is likely in the next few months, the Physicians and Hospitals of Western NC are going to have to decide which horse to support, which horse to ride.

We will see!

[Postscript: I think physicians are divided. If one has an attractive position with a major health system, the choice between hanging with fellow physicians in a collaborative, or hanging with the "health system," may be difficult .]