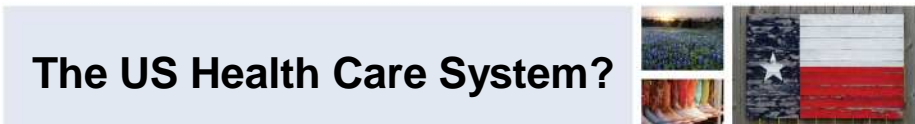


ACA, ACO, NCQA, PCMH, APM, BTE, OMG!

HFMA South Texas Chapter & Central Texas ACHE Joint Conference

Eduardo Sanchez, MD,MPH,FAAFP
Vice President and Chief Medical Officer
BlueCross and BlueShield of Texas
August 25, 2011



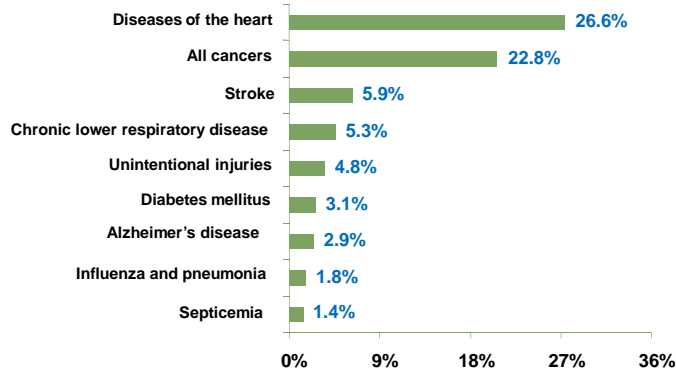
The US Health Care System?

“an expensive plethora of uncoordinated, unlinked, economically segregated, operationally limited microsystems each performing in ways that too often lead to suboptimal performance”

(Halvorson, 2007)

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Causes of Death, United States 2005



Source: cdc.gov

15 most expensive medical conditions (Druss et al, Health Affairs, Vol 21, #2, 2002)

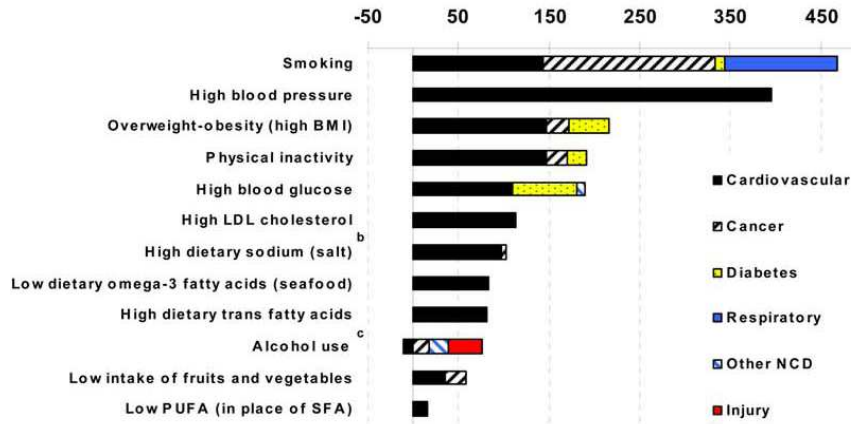


Condition	Est # with condition (millions)	National cost (\$billions)	Cost per capita (\$ per person)
Ischemic heart disease	3.4	21.5	6323.53
Motor vehicle accidents	7.3	21.2	2904.11
Acute respiratory infection	44.5	17.9	402.25
Arthropathies	16.8	15.9	946.43
Hypertension	26	14.8	569.23
Back problems	13.2	12.2	924.24
Mood disorders	9	10.2	1133.33
Diabetes	9.2	10.1	1097.83
Cerebrovascular disease	2	8.3	4150.00
Cardiac dysrhythmias	2.9	7.2	2482.76
Peripheral vascular d/o	3.4	6.8	2000.00
COPD	12.4	6.4	516.13
Asthma	8.6	5.7	662.79
Congestive heart failure	1.1	5.2	4727.27
Respiratory malignancies	0.3	5	16666.67

The Preventable Causes of Death in the United States: Comparative Risk Assessment of Dietary, Lifestyle, and Metabolic Risk Factors (Danaei,2009)



Deaths attributable to individual risk (thousands) in both sexes



The Affordable Care Act



- Expand coverage
- Remove barriers to coverage
- Address affordability issues

National Strategy for Quality Improvement in Health Care



- **Better Care:** Improve the overall quality, by making health care more patient-centered, reliable, accessible, and safe.
- **Healthy People/Healthy Communities:** Improve the health of the U.S. population by supporting proven interventions to address behavioral, social and, environmental determinants of health in addition to delivering higher-quality care.
- **Affordable Care:** Reduce the cost of quality health care for individuals, families, employers, and government.

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National Strategy for Quality Improvement in Health Care



- **Making care safer** by reducing harm caused in the delivery of care.
- **Ensuring that each person and family are engaged** as partners in their care.
- **Promoting effective communication and coordination** of care.
- **Promoting the most effective prevention and treatment practices** for the leading causes of mortality, starting with cardiovascular disease.
- **Working with communities to promote wide use of best practices** to enable healthy living.
- **Making quality care more affordable** for individuals, families, employers, and governments by developing and spreading new health care delivery models.

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The Cost Conundrum:
June 1, 2009 – Atul Gawande



- In 2006, Medicare spent \$15,000 per enrollee in McAllen, almost twice the national average.
- 2006 Medicare expenditures in El Paso were \$7,504 per enrollee

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co-nun-drum (noun)



- a riddle, the answer to which involves a pun or play on words
- What did one fish say to the other fish when they hit the brick wall?

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**McAllen And El Paso:
The BCBSTX experience**

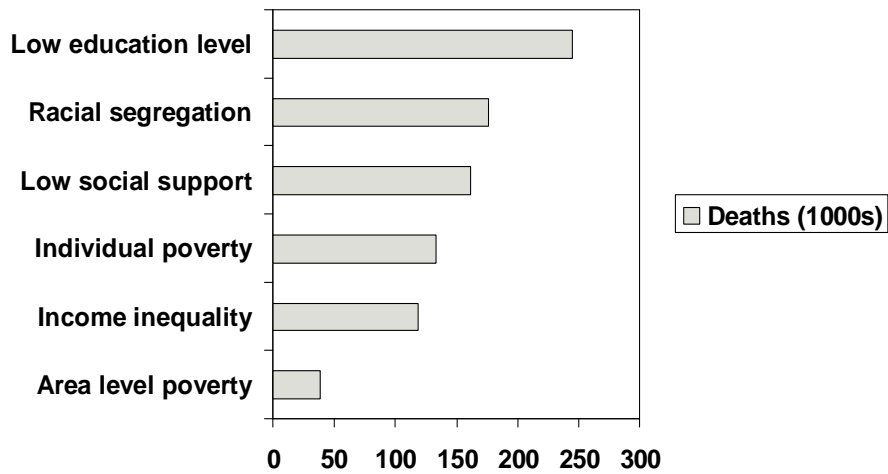


- In contrast to the Medicare population, the use of and spending per capita for medical services by privately insured populations (BCBSTX) in McAllen and El Paso was much less divergent
- Compared to El Paso, McAllen has a lower education level, lower per capita income, substantially more poverty, and more recently arrived immigrants.

Franzini, et al. *Health Affairs*, 29, no.12 (2010):2302-2309

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**Relationship between Social
Determinants and Mortality in 2000**



co-nun-drum (noun)



- anything that puzzles.
- What is an ACO?

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Accountable Care Organizations (ACOs)



- Defined as a set of providers associated with a defined set of patients, accountable for the quality and cost of care for that population.
- The providers could include a hospital, a group of primary care providers, specialists, and other health professionals who share responsibility for the quality and cost of care provided to patients.
- Hospitals are not a necessary part of ACOs, but seem to be taking the lead.
- An ACO is responsible for a patient wherever he or she elected to get care.
- ACOs receive a financial bonus for meeting certain prescribed targets.

(AcademyHealth, 2009)

ACO Structure and Formation: Eligible Organizations

- ACO Composition: Multiple configurations are possible
- ACOs must have a mechanism for shared governance to participate in the Shared Savings Program
- ACOs are required to enter into a three-year contract with CMS.
- ACOs must have at least 5,000 beneficiaries and a commensurate number of primary care physicians.

SNR DENTON 

ACO Structure and Formation: Governance

- Board Composition: Governing board must be representative of the organizations comprising the ACO.
 - Must include a Medicare beneficiary representative
- Possess broad responsibility for the ACO's administrative, fiduciary and clinical operations.
- ACO participants must have at least 75 percent control of the governing body.

SNR DENTON 

ACO Structure and Formation

- **Leadership and Management**
 - Staffing
 - Systems – quality focused, evidence-based

- **Contractual Obligations to CMS**

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Payment: Quality and Shared Savings

- ACO providers will continue to be paid under the Medicare fee-for-service payment systems throughout participation in the ACO.
- To realize shared savings, ACOs must exceed a benchmark set by CMS.
- 65 Quality Measures divided between 5 domains
 - (1) Patient/Caregiver Experience;
 - (2) Care Coordination;
 - (3) Patient Safety;
 - (4) Preventive Health;
 - (5) At-Risk Population/Frail Elderly Health.
- Methodologies and models described

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Other issues

- Fraud and Abuse
- Antitrust

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New ACO Rules Outline Gains And Risks For Doctors, Hospitals



- It is estimated that between 75 and 150 ACOs would be formed and approved by CMS.
- They would care for anywhere between 1.5 million and 4 million Medicare beneficiaries.
- The Centers for Medicare & Medicaid Services anticipated the new ACOs could save Medicare between \$170 million and \$960 million over three years out of \$1.8 trillion during this period. [less than 0.055%]
- But ACO proponents hope these new models would proliferate and be expanded for privately insured patients.

www.kaiserhealthnews.org/Stories/2011/March/31/ACO-rules.aspx

New ACO Rules Outline Gains And Risks For Doctors, Hospitals



- Initial costs, which include installing electronic health records to link all the different specialists and facilities so they can share information with each other and CMS, will be a challenge.
- The government estimated the first year start-up and operation costs for all the ACOs would total between \$132 million and \$263 million. [\$1-2 million per ACO?]
- "... first couple of years of the operation of these organizations don't typically achieve a great level of efficiency and it takes time and investment costs to get it going,"
- In an earlier model of ACOs that CMS experimented with, the Physician Group Practice Demonstration, only six of 10 participating groups earned bonuses over three years.

www.kaiserhealthnews.org/Stories/2011/March/31/ACO-rules.aspx

BCBSTX Desired ACO Characteristics



- Primary Care foundation
- Provider and payer collaboration
- HIT/connectivity
- Population management systems
- Care coordination
- Cost efficiency focus
- Quality thresholds
- Shared Savings → fixed payment (risk adjusted)

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Desired Outcomes



- Improved prevention and early diagnosis of conditions
- Decreased unnecessary testing, referrals and medications
- Chronic disease management
- Decreased emergency room visits
- Avoidable hospital admissions
- Reduced Healthcare acquired infections
- Reduced Hospital complications
- Reduced Hospital readmissions
- Lower cost treatments/conservative medicine
- Lower cost place of service
- Lower cost and/or cost efficient providers

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ACO Barriers



- Primary care shortage
- FFS system
- Lack of alternative payment arrangements with incentives
- Unaffiliated/uncoordinated providers
- Lack of HIE/HIT
- Financing for population management systems
- Loss of revenue to some providers
- Antitrust concerns
- Significant resources required

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ACO Realities



- Multiple year process
 - Providers need time to transform
 - Providers at different stages
 - Providers, payers and employers must define a collaborative model
 - Provider accountability and capabilities will grow over time
 - Not all providers will be part of ACO's
- Purchasers and payers must see value to support
- Consumers must engage in quality and cost effectiveness value proposition

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Implementing Accountable Care Organizations Ten Potential Mistakes and How to Learn From Them



- **1. Overestimation of Ability to Manage Risk.**
- **2. Overestimation of Ability to Use Electronic Health Records.**
- **3. Overestimation of Ability to Report Performance Measures.**
- **4. Overestimation of Ability to Implement Standardized Care Management Protocols.**
- **5. Failure to Balance the Interests of Hospitals, Primary Care Physicians, and Specialists in Creating Governance and Management Processes to Adjudicate Differences.**

Singer and Shortell, JAMA.2011;306(7):758-759.

Implementing Accountable Care Organizations Ten Potential Mistakes and How to Learn From Them



- **6. Failure to Sufficiently Engage Patients in Self-care Management and Self-determination.**
- **7. Failure to Make Contractual Relationships With the Most Cost-Effective Specialists.**
- **8. Failure to Navigate the New Regulatory and Legal Environment.**
- **9. Failure to Integrate Beyond the Structural Level.**
- **10. Failure to Recognize the Interdependencies and Therefore the Potential Cumulative “Race to the Bottom” of the Above Mistakes.**

Singer and Shortell, JAMA.2011;306(7):758-759.

Refocus on People



- The Objective? - Improving the health of a population

The Frame: Triple Aim



- Coined by the Institute for Healthcare Improvement (IHI) which believes that new designs can and must be developed to simultaneously accomplish three critical objectives
 - **Improve the health of the population;**
 - **Enhance the patient experience of care (including quality, access, and reliability); and**
 - **Reduce, or at least control, the per capita cost of care.**

High Medical Care Cost



- Five percent of the population accounts for 49 percent of total health care expenses.
- The 15 most expensive health conditions account for 44 percent of total health care expenses.
- Patients with multiple chronic conditions cost up to seven times as much as patients with only one chronic condition.

AHRQ, Research in Action, 2006

The Hot Spotters: January 24, 2011 –
Atul Gawande



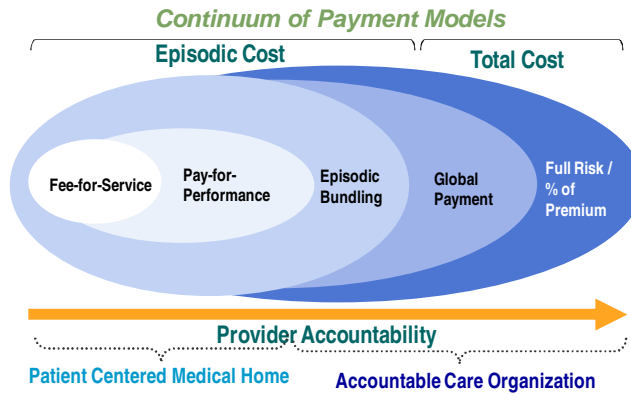
- Can we lower medical costs by giving the most at risk, the sickest, the most costly patients targeted care?

A deep breath.....



FunnyAnimalSite.com

Align Reimbursement & Desired Outcomes

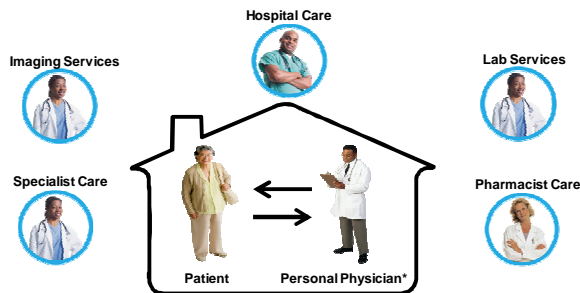


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Patient Centered Medical Home Model



Redesigning the Way Primary Care is Delivered and Financed



- Trusted personal physician
- Physician who provides, manages and facilitates care
- Care is coordinated or integrated across healthcare system
- More accessible practice with increased hours and easier scheduling
- Payment mechanisms that recognize the added value of delivering care through the PCMH model
- Assistance to practices seeking transformation
- Support to practices adopting HIT for QI

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* Includes Non Physician Professionals

The Potential Impact of Medical Home



2.8 million

Members participating, 31 different states (*Blue Cross Association, January 2011*)

Early results

29% reduction in admissions

17% reduction in ER visits



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Accountable Practice Model



- Primary Care/Medical Home focus – in a POS/PPO environment
- Standard practice evaluation criteria based on NCQA must pass elements
- Standard set of quality metrics (primarily NCQA based)
- Shared Savings model
 - Historical population trend performance
 - Year 1 Target Trend: Historical 3 year average trend less trend reduction percentage
 - Year 2 – Year 3 Target Trend: Movement toward floor of general CPI
 - Savings only shared if quality metric performance is attained
- Care coordination payment
 - Software, Outreach services, Mailers, Increased time with physician, IT support
- Data sharing
- Collaborative chronic condition, case and trend management
- Performance measurement

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Texas Medical Home Initiatives:

Current and Future




BCBSTX Pilots

Eff. February 1, 2010

Medical Clinic of North Texas

- 131 total physicians
- 88 Primary Care Physicians

Village Health Partners (Plano)

- 10 total physicians
- 10 Primary Care Physicians

Client Participation in Pilots

- 26 Asthmatics
- 80 Coronary Artery Disease
- 214 Diabetics
- 3,100 eligible for various preventive screenings

Accountable Practice Models Medical Home/ACO Hybrid

Effective date: January 1, 2011

Austin Regional Clinic (Austin)

- 288 total physicians
- 159 Primary Care Physicians


Kelsey Seybold (Houston)

- 379 total physicians
- 195 Primary Care Physicians

Trinity Clinics (Tyler)



- 269 total physicians
- 92 Primary Care Physicians

Total physicians includes PCPs. Total PCPs include IM, Family, and Peds.




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Bridges to Excellence Overview

- Mission is to improve quality of care by recognizing and rewarding physicians who have implemented comprehensive solutions in the management of patients
- Clinicians and practices **voluntarily** submit to an independent **performance assessment organization (PAOs)** for scoring
- Data Aggregators (BTE Approved Registries) collect the data from clinicians
- Performance assessment pathways include:
 - National Committee for Quality Assurance (NCQA)
 - New York's Quality Improvement Organization (IPRO)
 - Automated EMR/Registry System
 - American Board of Internal Medicine (ABIM)



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BCBSTX BTE Update



- Identify and reward health care providers who deliver high-value diabetes care to adult patients
- Adult patients receive care from primary care physicians (PCPs), endocrinologists and non-physician providers for treatment of their diabetes
- Diabetes Care Recognition program has the potential to significantly improve the quality of care experienced by patients with diabetes and to reduce the financial and human burden of unnecessary hospitalizations and complications

BTE Results



Several studies have shown how BTE participation leads to:

Improved Performance

- Outperform non-recognized physicians on process measures quality

Better Patient Health

- Have fewer episodes per patient and lower resource use per episode

Reduces Costs

- Have lower average costs per patient and per episode

BCBSTX Diabetes Care Program

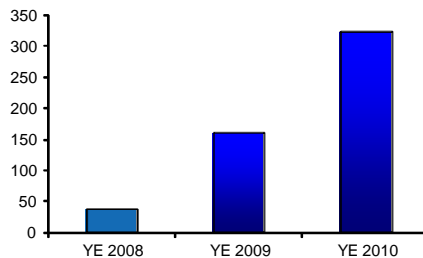


- BTE recognized physicians will be eligible for a financial reward of \$100 per BCBSTX patient per program year.
- Unlimited number of patients per physician or group per program year.
- Unlimited maximum payout.

Bridges to Excellence Diabetes Success in Recruiting Providers



- The program has experienced a remarkable increase in BTE recognized physicians since year end 2008
- 39 physicians as of Dec, 2008 to 325 in Dec, 2010



- **Total Savings PMPM: \$100**

Hospital Pay for Performance

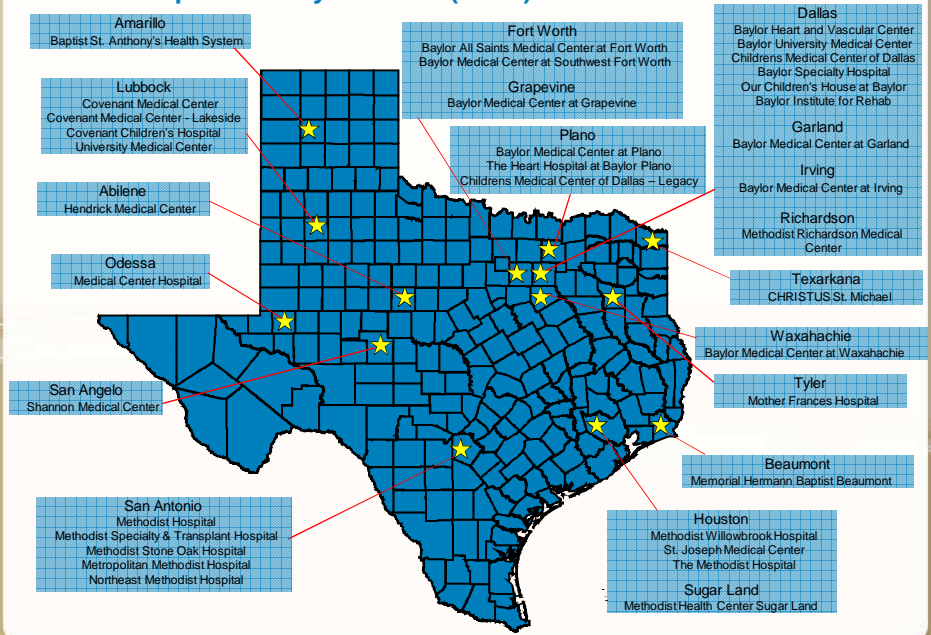
- Core community quality and efficiency metrics – readmissions, complications, infection rates
- Other quality standards including patient satisfaction
- Tied to employer, member and provider transparency
- Shared Savings/performance payments → fixed payment (risk adjusted)
- Precursor to ACO development



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43

Texas Hospital Quality Initiative (THQI) Locations



44

Texas Center for Quality & Patient Safety

Initially focused on a collaborative to reduce or eliminate central line-associated bloodstream infections in hospital intensive care units.

- 40 intensive care units in 25 Texas hospitals and health systems are participating in the project,
- which will expand to include more hospitals in FY 2011 with funding from a grant from TDSHS.

Central line infections reduced from 3/1000 central line days to 1.3/1000 central line days in 25 hospitals

2nd wave of hospitals to focus on bloodstream, urinary tract, or surgical site infection prevention.

Readmission reduction initiative set to launch in 2011:

- an initiative designed to reduce hospital readmissions occurring within 30 days of discharge



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The Hot Spotters: January 24, 2011 – Atul Gawande



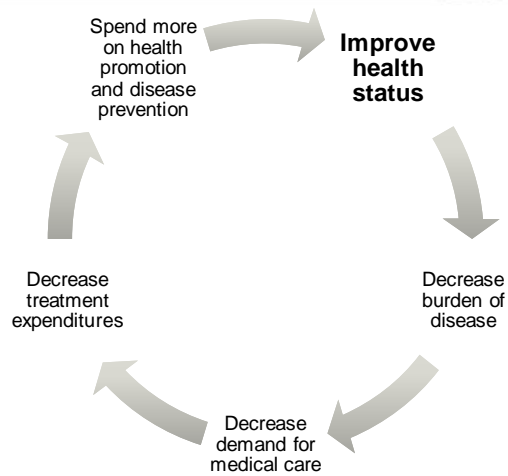
- Can we lower medical costs by giving the most at risk, the sickest, the most costly patients targeted care?
 - **BCC?** – lifestyle and condition management
 - **APM?** – a medical home with care coordination
 - **BTE?**
 - **IOCP?** - Intensive outpatient care for the 10-15% highest risk members of the population delivered through primary care team-led, highly coordinated, rules-based, intentional, proactive care management

15 most expensive medical conditions by overall cost (BCBSTX Book of Business Benchmark)



Condition	Prevention	Management	Treatable in primary care
Ischemic heart disease	BCC, PCMH	BCC, BTE	yes
Ortho - Back	BCC	PCMH	With ortho
Chronic renal failure	DM/HTN related	Case mngmnt	nephrology
Hypertension	BCC	PCMH	yes
Diabetes	BCC	BCC, BTE	yes
Routine exam	BCC	PCMH	yes
Malignant breast neoplasm	BCC/MMG	yes	oncology
Pregnancy with delivery	yes	Special beginnings	OB
Other minor perinatal disorder	yes	Special beginnings	Specialist(s)
Ortho - Knee ,lower leg	BCC	yes	With ortho
Ortho - Neck	yes	yes	With ortho
Cerebrovascular disease	BCC	yes	yes
Nonmalignant neoplasm gyn	BCC	Gyn	gynecology
Cholelithiasis	BCC	PCMH+	surgery
Mood disorder, depressed	BCC/EAP	BH,PCMH	yes

The Health Spiral



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ACO Realities



- Multiple year process
 - Providers need time to transform
 - Providers at different stages
 - Providers, payers and employers must define a collaborative model
 - Provider accountability and capabilities will grow over time
 - Not all providers will be part of ACO's
- Purchasers and payers must see value to support
- Consumers must engage in quality and cost effectiveness value proposition

Concluding Comments



- **Accountable Care Organizations**
 - Conceptually compelling
 - Intellectually enticing
 - Administratively burdensome
 - Realistically challenging

Public Health Spending Linked to Declines in Preventable Deaths



Mortality rate	Percent decrease per 10% spending increase
Infant deaths per 1000 live births	6.85
Heart disease deaths per 100,000	3.22
Diabetes deaths per 100,000	1.44
Cancer deaths per 100,000	1.13
Influenza deaths per 100,000	0.25

Mays and Smith, Health Affairs. Aug 2011;30(8).

Improve the health of the population



Accountable Health Organizations

- Defined as a set of social services, health, and medical providers associated with a defined population, accountable for the health status and outcomes for that population.
- The providers could include a local health department, health plans, employers, primary care providers, specialists, and other health professionals who share responsibility for the quality and cost of care provided to patients in addition to the health of all.
- Local health departments and health plans (public and private) should be taking the lead.
- AHOs are rewarded for optimizing health.

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The Future – from the BCBSTX Perspective



- Policy Focus – Inform policy makers and policy that is made
 - Washington DC
 - Austin
- Execution – Comply with the law
 - Participate in rule making
- Strategy
 - Short term – keep members healthy
 - 2014 considerations - exchanges
 - Future – be positioned to adjust

Concluding Comments



- As goes CMS so goes health care?
 - Situational awareness – know what's going on around you
 - Make the best decisions you can with the information you have
 - Leave yourself as many options open as possible
 - Be prepared to make adjustments
- Health is a team sport
 - Communication
 - Coordination
 - Collaboration

