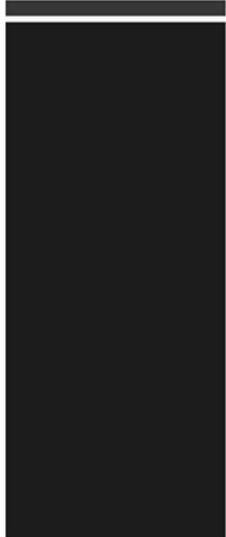


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Academic Medical Centers: Building a Successful ACO

November 12, 2019

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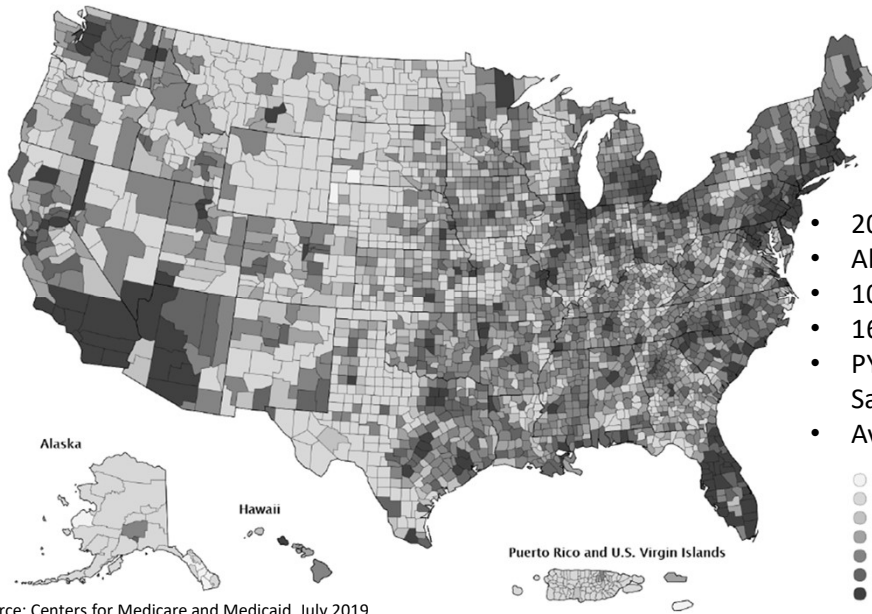
Agenda

- Opening Comments and Context
- Learning Objectives
- Introductory Remarks by Panelists
- Panel Discussion
- Audience Q&A

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Medicare Shared Savings Program ACO Assigned Beneficiary Population by County



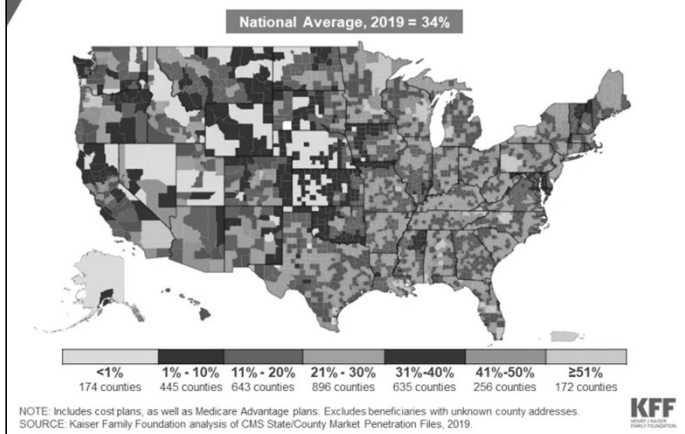
- 2019 - 518 Medicare ACOs
- About 2/3 of AMC participate
- 10.9 M Beneficiaries
- 16% of Medicare Beneficiaries
- PY 2017 Total Earned Shared Savings = \$800 M
- Average Quality Score = 92.4%

Source: Centers for Medicare and Medicaid, July 2019

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Figure 3
Medicare Advantage Penetration, by County, 2019



NOTE: Includes cost plans, as well as Medicare Advantage plans. Excludes beneficiaries with unknown county addresses.
SOURCE: Kaiser Family Foundation analysis of CMS State/County Market Penetration Files, 2019.



2019 Medicare Advantage Enrollment

- 22 million
- 34% of Medicare Beneficiaries

List of States/Territories => 39% Penetration








- Alabama
- California
- Connecticut
- Florida
- Michigan
- New York
- Oregon
- Puerto Rico
- Pennsylvania
- Wisconsin

Source: Kaiser Family Foundation: A Dozen Facts About Medicare Advantage in 2019

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Example from Los Angeles: Evidence of Changing Relationships between Health Plans/Government & Health Systems

 <p>All forms of original Medicare now have downside financial risk</p> <table border="1"> <tr> <td>Medicare Part B</td> </tr> <tr> <td>MACRA (MIPS & APM bonus)</td> </tr> </table> <table border="1"> <tr> <td>Medicare Part A & B</td> </tr> <tr> <td>Bundle Payments, MSSP, Other newer models (APM bonus link)</td> </tr> </table>	Medicare Part B	MACRA (MIPS & APM bonus)	Medicare Part A & B	Bundle Payments, MSSP, Other newer models (APM bonus link)	<p>PPO Plans have multi-year goals to increase financial (downside) risk in contracting; their focus is Total Cost of Care</p>
Medicare Part B					
MACRA (MIPS & APM bonus)					
Medicare Part A & B					
Bundle Payments, MSSP, Other newer models (APM bonus link)					
 <p>Medicare Beneficiaries: Enrollment in Medicare Advantage (Part C) in California is now 40%</p>	<p>Medi-Cal funding is being used to encourage the evolution of California's health delivery: State incentive funding to public hospitals now dependent upon participation in Managed Medi-Cal</p>  				
  <p>Development of "narrow networks"; Defined by lower cost</p>	 <p>Rapid Expansion of Employer Self-Funded Plans</p>				

Medicare: Part A Hospital Payments; Part B Professional Payments; Part C Medicare Advantage; Part D Drug Plans
MIPS = Merit-based Incentive Payment System
APM = Advanced Alternative Payment Model

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Learning Objectives

- Explore models used in Academic Medical Center (ACM) ACOs for successful contracting and network development.
- Understand different approaches and investment necessary to design and develop an infrastructure to successfully manage a higher-risk population.
- Define steps to address major challenges arising during the movement to value-based care.

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Panel Discussion

Ann L. Boynton, MA
Director, Payer Strategies & Value-Based
Contract Management, UC Davis

Jennifer Houlihan, MSP, MA
VP Value-Based Care & Population Health,
Wake Forest Baptist Medical Center

Samuel A. Skootsky, MD
Chief Medical Officer, UCLA Faculty Practice
Group and Medical Group



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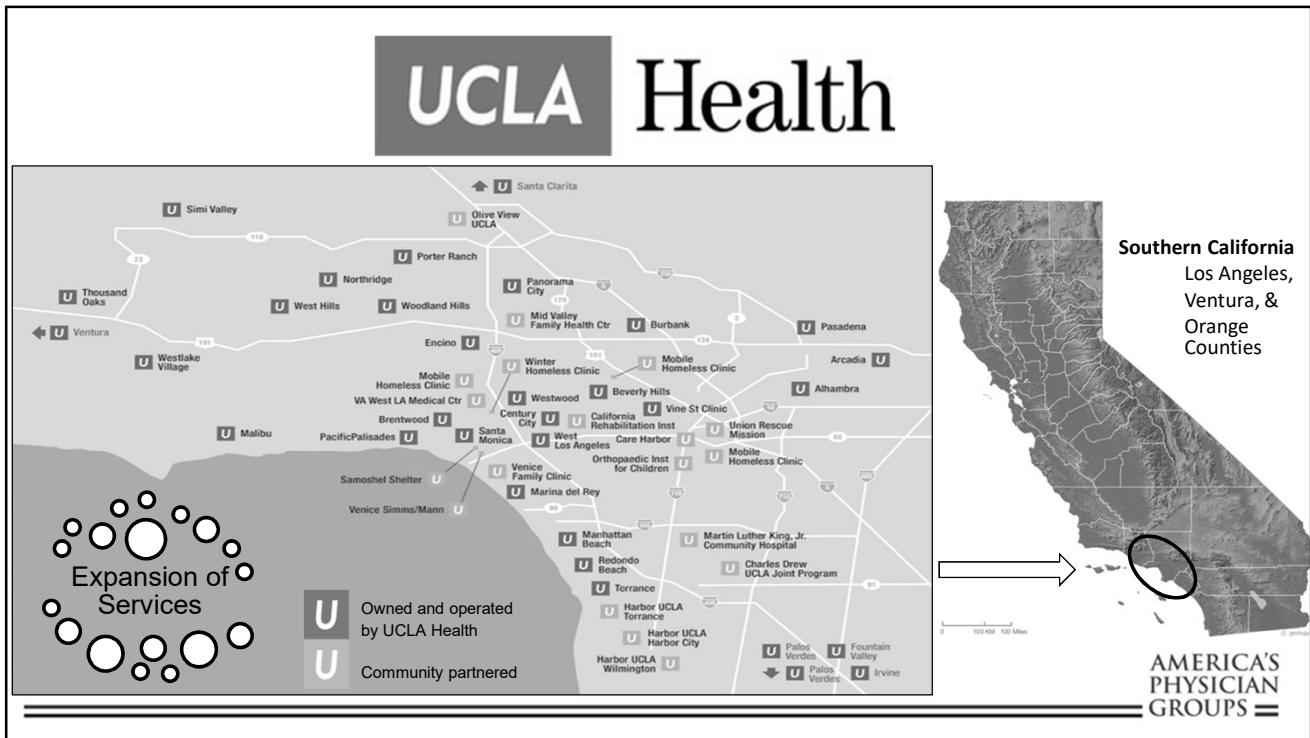


UCLA Health

Samuel A. Skootsky, MD
Chief Medical Officer, UCLA
Faculty Practice Group and
Medical Group

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- **Ambulatory**
 - 180 sites
 - 2140 employed physicians
 - 370 employed primary care physicians
 - 370,000 attributed primary care patients
 - 3.5 million encounters annually
- **Hospital**
 - UCLA Hospitals: 2 acute, 1 psychiatric, and 1 children's hospital
 - 41,000 annual discharges
 - Community Hospitals Used: 18 (in LA, Ventura, and Orange Counties)
- **Risk Bearing entity**
 - UCLA Health (UCLA Medical Group & UCLA Hospitals)
- **Significant patient population product lines**
 - Commercial PPO & ACO
 - Original Medicare
 - Commercial HMO & ACO
 - Medicare Advantage
 - Other contracted
- **CMS Bundle Payment**
 - CJR (Joint Replacement)
- **T/Q case rates**

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Spectrum of Contracts

	Fee for Service (FFS)	Pay for Performance	APMs Built on FFS Architecture	APM built on Population Based Payments
	<i>No Link to Quality and Value</i>	<i>Linkage to Quality and Value</i>	<i>Population Based or Bundles</i>	<i>e.g. Capitation</i>
% Patients	61%	19%	10%	10%

Approximately 125,000 patients in risk-based/APM models

APM = Alternative Payment Model

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**UCDAVIS
HEALTH**

Ann L. Boynton, MA
Director, Payer Strategies
& Value-Based Contract
Management, UC Davis

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UCDAVIS HEALTH

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4

UCDAVIS HEALTH

- 625-bed multispecialty academic medical center & designated Public Hospital
- Only level 1 trauma for both adult & pediatric for inland Northern California
- 33 counties covering a 65,000-square-mile area north to the Oregon border and east to Nevada

ER Visits	80,574	Faculty & Academic	1,526
Clinic/Office Visits	908,542	Residents & Fellows	933
Admissions	34,763	Students	1,009
Observation Days	7,188	Staff	11,310

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Spectrum of Contracts

	Fee for Service (FFS)	Pay for Performance	APMs Built on FFS Architecture	APM built on Population Based Payments
	<i>No Link to Quality and Value</i>	<i>Linkage to Quality and Value</i>	<i>Population Based or Bundles</i>	<i>e.g. Capitation</i>
% of Patients	50%	3%	36%	11%

Approximately 77,500 patients in risk-based/APM models

APM = Alternative Payment Model

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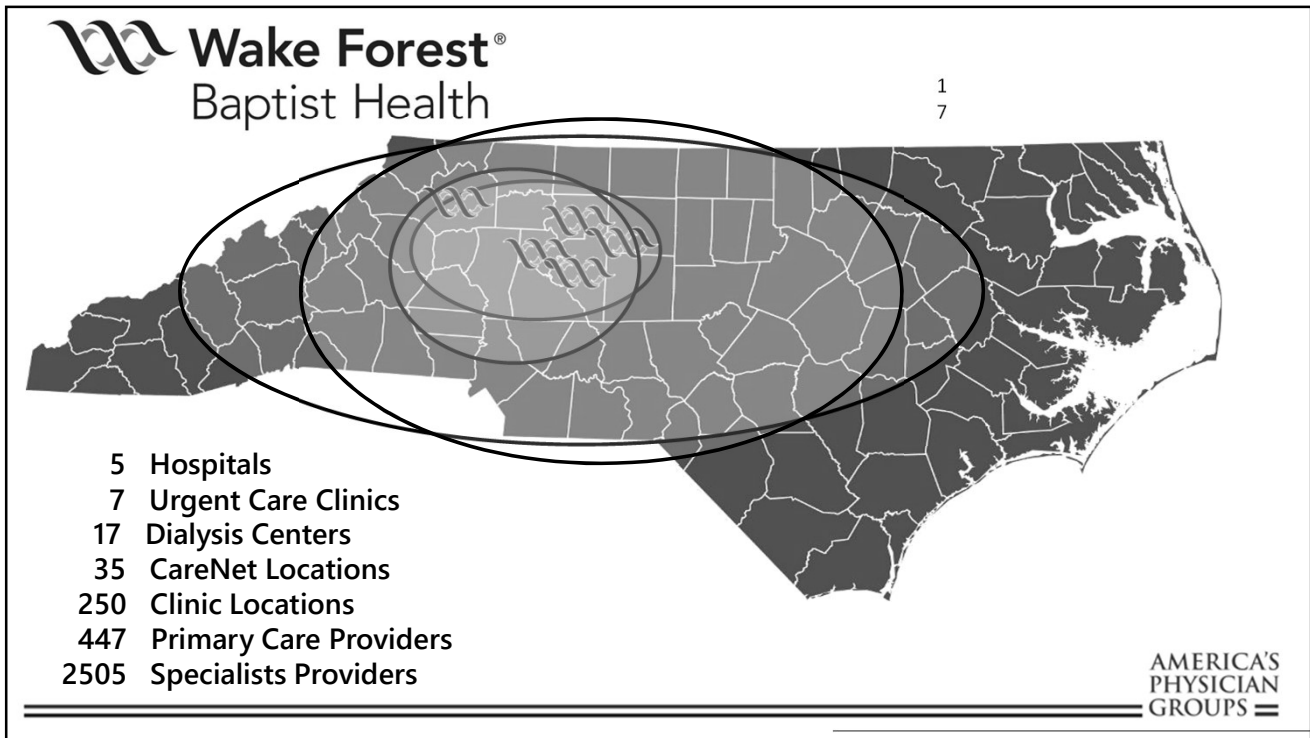


Wake Forest[®]
Baptist Health

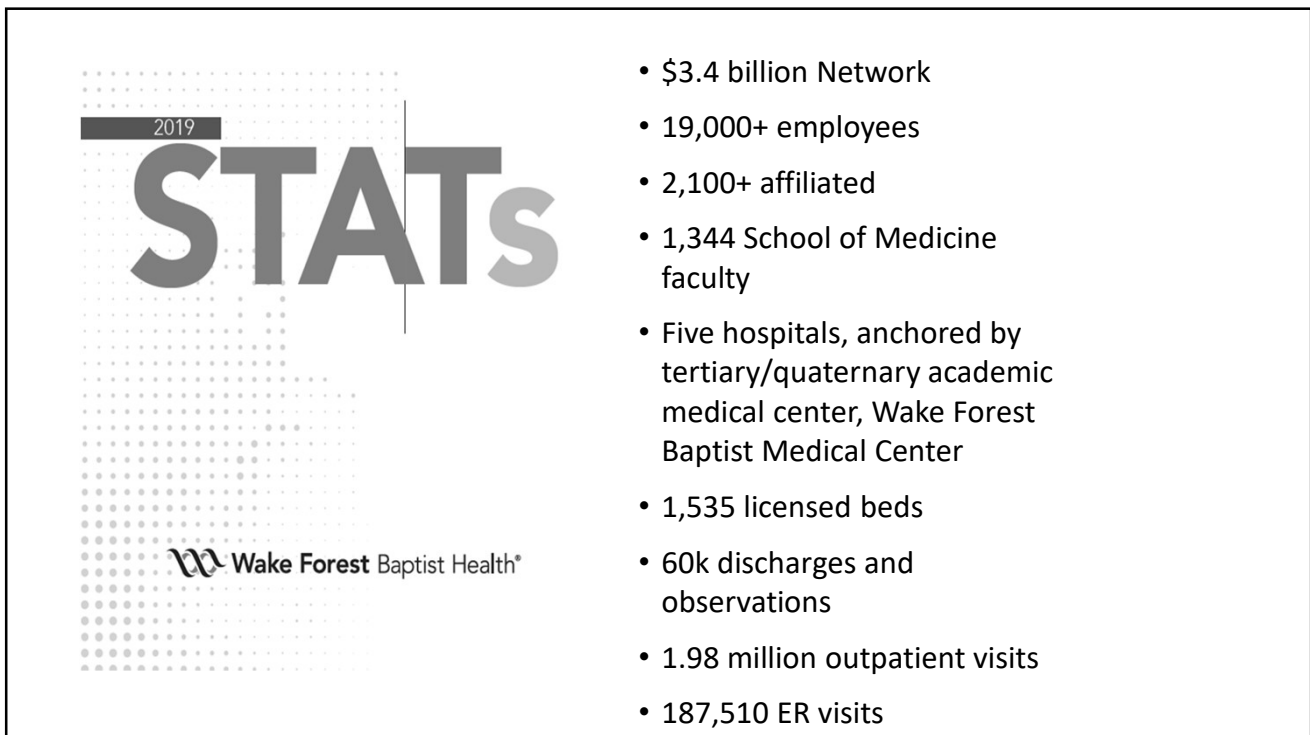
Jennifer Houlihan, MSP
VP Value-Based Care &
Population Health, Wake Forest
Baptist Medical Center

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Spectrum of Contracts¹₉

	Fee for Service (FFS)	Pay for Performance	APMs Built on FFS Architecture	APM built on Population Based Payments
	<i>No Link to Quality and Value</i>	<i>Linkage to Quality and Value</i>	<i>Population Based or Bundles</i>	<i>e.g. Capitation</i>
% of Patients	17%	50%	33%	---

Total Managed Lives Under Risk Based/APMs = 120,000

APM = Alternative Payment Model

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Panel Discussion

Audience Q&A

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