CPR-PBGH Toolkit for Purchasers on Accountable Care Organizations

June 26, 2014
Overview

• Introductions

• The Current ACO Landscape

• ACO Options Available to Employers Today

• Features of the Ideal ACO

• CPR-PBGH ACO Toolkit Components:
  • ACO How-To Guide
  • ACO RFI
  • ACO Model Contract Language
  • Health Plan ACO Performance Guarantee

• Discussion/Lessons Learned
Accountable Care Organizations

Kavita K. Patel MD, MS

Engelberg Center for Health Care Reform
The Brookings Institution

June 2014
ACO Guiding Principles

<table>
<thead>
<tr>
<th>Core Principles</th>
<th>Key Design Elements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clarify aims</strong> to emphasize better health, better quality care, lower costs - for patients and communities</td>
<td>▪ Pay for better value - improved overall health while reducing costs for patients</td>
</tr>
<tr>
<td><strong>Better information</strong> that engages physicians, supports improvement, and informs consumers</td>
<td>▪ Provide timely feedback to providers ▪ Require providers to report on utilization and quality</td>
</tr>
<tr>
<td><strong>New model: It’s the system</strong> - Establish organizations accountable for aims and capable of redesigning practice and managing capacity</td>
<td>▪ Establish robust HIT infrastructure ▪ Implement cost-saving and quality-improving medical interventions ▪ Evaluate performance at the system level</td>
</tr>
<tr>
<td><strong>Realign incentives</strong> - both financial and clinical - with aims</td>
<td>▪ Restructure payment incentives to support accountability for overall quality and costs across care settings</td>
</tr>
</tbody>
</table>
Savings Based on Spending Targets

- ACO Launched
- Projected Spending
- Target Spending
- Shared Savings
- Actual Spending

Year: -3, -2, -1, 0, 1, 2, 3

Spending graph showing savings based on spending targets with various spending targets and savings indicators.
Growth of ACOs Over Time

Medicare vs. Non-Medicare ACOs

# of ACOs

Q4 2010
Q1 2011
Q2 2011
Q3 2011
Q4 2011
Q1 2012
Q2 2012
Q3 2012
Q4 2012
Q1 2013
Q2 2013
Q3 2013
Q1 2014

Medicare

Non-Medicare

Total

Q4 2010
Q1 2011
Q2 2011
Q3 2011
Q4 2011
Q1 2012
Q2 2012
Q3 2012
Q4 2012
Q1 2013
Q2 2013
Q3 2013
Q1 2014
Updated as of January 2014. Sources: News releases, company websites, Dartmouth Atlas PCSAs, Claritas, Oliver Wyman analysis

% of residents with access to ACOs

- Low <50%
- Medium 50-75%
- High >75%
<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare ACO Beneficiaries</td>
<td>5.6 Million</td>
</tr>
<tr>
<td>Non-Medicare Patients Served by Medicare ACO</td>
<td>&gt;33 Million</td>
</tr>
<tr>
<td>Medicaid ACOs</td>
<td>34 across 19 states</td>
</tr>
<tr>
<td>Commercial ACO Contracts</td>
<td>287</td>
</tr>
<tr>
<td>Private Sector ACOs Beneficiaries</td>
<td>9 to 16 Million</td>
</tr>
</tbody>
</table>

Sources: “Fast Facts- All Medicare Shared Savings Program and Medicare Pioneer ACOs” May 2014; State “Accountable Care” Activity Map, National Academy for State Health Policy; “ACO Results: What We Know So Far” Leavitt Partners April 25, 2014; “ACO Update: Accountable Care at a Tipping Point Oliver Wyman April 2014
109/114 Medicare Shared Savings Program (MSSP) ACOs and all 32 Pioneer ACOs successfully reported quality measures.

- Similar average quality performance but considerable variation in reported quality.
- Better performance than quality benchmarks (now set based on performance data).
- Better performance than Medicare FFS on measures with FFS data (colorectal cancer screening, tobacco cessation, depression screening).
- Higher CAHPS patient experience survey scores than Medicare FFS.
MSSP and Pioneer ACO First-Year Results:

- **MSSP:** Medicare spending growth benchmark 0.8%
  - 54/114 MSSP ACOs had lower spending than benchmarks, and 29 reduced spending growth enough to share in savings
  - 21 of 29 successful MSSP ACOs were physician-led
  - Two MSSPs had shared losses
  - Total shared savings to MSSP ACOs of $126 million; $128 million in Medicare savings (approx 1% overall savings)

- **Pioneer:** Medicare spending growth benchmark 0.3%
  - 13/32 Pioneer ACOs reduced spending growth enough to share in savings
  - One Pioneer ACO had shared losses of approx. $2 million
  - Total shared savings of $76 million; $71 million in Medicare savings (approx 2% overall savings)
Medicaid ACO Activity

Source: “State Accountable Care Activity” Map National Academy for State Health Policy
Early Results from Private-Plan ACOs

Cigna

- 89 ACO initiatives in 27 states serving 910,000 commercial customers, with plans to increase to 100 ACOs by the end of 2014, reaching one million customers
- **Early results**
  - On average, 3% better-than-market quality performance
  - On average, 3% better-than-market total medical cost
  - 19% to 25% better compliance with diabetes measures;
  - 21% more gaps in care closed
  - 50% fewer emergency room visits

Aetna

- 32 ACO agreements in place serving 550,000 members, with plans to increase to 60 ACOs by the end of 2014 to cover 750,000 members, amounting to $2.5 billion or 7% of its total revenue
- **Early results**: ACOs have generated 10% savings on average
WellPoint ACOs
- 85 ACOs, a rapid increase from the 23 ACO contracts it had in May 2013

Anthem ACOs
- 14 ACOs serving 55,000 patients in Southern California in PPO plans
- Partnerships with HealthCare Partners, Santa Clara County IPA, Sharp Community Medical Group and Sharp Rees-Stealy Medical Group
- **Early results** showed 35% year-over-year increase in the number of mammograms performed and a 44% increase in appropriate prescribing of antibiotics for bronchitis treatment by the end of 2013
- Cost savings reported in early June of 2014 by Anthem in partnership with HealthCare Partners
  - Net savings of $4.7 million achieved in the first half of 2013, in conjunction with care coordination fee implementation
  - Overall admissions fell by 4%
  - Inpatient days fell by 18%
  - Visits for radiology and other lab tests fell by 4%
Early Results from Private Plan ACOs

UnitedHealthcare
ACOs and Patient-Centered Medical Homes across 29 states

- Programs designed via five value levers: evolved care management programs; high-performing networks; value-based contracting; value-based benefits; and transparency and all involve shared risk and savings between both the health plan and care provider
- $30 billion of UnitedHealthcare’s annual physician and hospital reimbursements are linked to its accountable care programs, centers of excellence and performance-based programs with the goal to reach $65 billion by 2018

- **Early results**
  - 4 Star HEDIS level on screenings for diabetes, cardiovascular care, colorectal cancer and rheumatoid arthritis for Medicare Advantage plan accountable care programs
  - PCMH in OH, CO, RI, & AZ resulted in overshooting clinical quality targets on **95%** of measures, 2:1 medical cost savings as compared to incentive payout and reduced medical cost trend by **4% to 4.5%** points
1. Rapid and diverse growth and development of ACOs

- Commercial contracts have more than doubled in the past 2 years
- Medicare ACOs are forming in all parts of the country with different organizational models: metropolitan, rural, suburban, hospital-based, physician-led, PHOs, FQHCs
- Medicaid ACO activity is growing rapidly across the country in various stages of development: fully implemented with results (CO, OR), entering implementation (NJ, IL), proposed reforms (NC)

2. Wide variation in pace and types of ACO activity

- ACOs in both the public and private sector are in different stages of development with varying levels of risk ranging from “downside” only to full capitation
- Some organizations see ACOs as an end product; others are using ACOs as transition path to increasingly advanced payment and delivery models

3. Mixed results including some strong successes and some with little early impact

- Medicare ACOs are meeting quality benchmarks, but only a quarter have been able to reduce costs enough to qualify for shared savings
- Many commercial ACOs have been able to transform care, and in some cases bend the cost curve (ranging from 2 to 12%), but success can often be determined by market changes or factors beyond scope of ACO
4. Increasing opportunities to learn from ACO experience

- Diversity in implementation steps, with chances to learn how to innovate more effectively
- Right strategy and implementation steps depend on context

5. Progress in payment reform and implementation support

- Moving beyond shared savings: ongoing physician payment reform efforts, bundled payments, medical homes
- New mechanisms to provide capital needed to support practice change

6. Further policy reforms coming

- CMS is expected to release new proposed regulations for the Medicare ACO programs—opportunities to address existing issues and create sustainable path forward
- Further state reform initiatives
- Potential further steps on antitrust and consolidation
### Proportion of ACOs

- **Physician-led**: 51%
- **Jointly led by physicians and hospital**: 33%
- **Hospital-led**: 6%
- **Coalition-led**: 6%
- **State, region, or county-led**: 1%
- **Federally Qualified Health Center-led**: 1%
- **Some other arrangement**: 5%

### Physicians Represent Majority on Governing Board
- **Physician-led**: 94%
- **Jointly led by physicians and hospital**: 65%
- **Hospital-led**: 20%
- **Coalition-led**: 80%
- **State, region, or county-led**: 50%
- **Federally Qualified Health Center-led**: 0%
- **Some other arrangement**: 60%

### Physicians Own Equipment and Employ Staff
- **Physician-led**: 62%
- **Jointly led by physicians and hospital**: 16%
- **Hospital-led**: 0%
- **Coalition-led**: 25%
- **State, region, or county-led**: 0%
- **Federally Qualified Health Center-led**: 0%
- **Some other arrangement**: 29%
Outlook on the ACO Model

In the nation: Anticipate half or more patients covered by ACO-like contracts in 5 years
- Physician-Led ACOs: 54%
- Other ACOs: 33%

In your market: Anticipate half or more patients covered by ACO-like contracts in 5 years
- Physician-Led ACOs: 77%
- Other ACOs: 82%

ACO contracts have great potential to improve quality
- Physician-Led ACOs: 64%
- Other ACOs: 44%

ACO contracts have great potential to reduce cost growth
- Physician-Led ACOs: 42%
- Other ACOs: 36%
73% include a hospital
74% include post-acute care
28% include an FQHC or RHC
Average of 179 PCPs, 241 specialists for largest ACO contract

50% reporting physician performance measures on quality among peers within organization
33% reporting physician performance measures on cost among peers within organization
46% utilize individual financial incentives
Health IT

- 87% attested to *Meaningful Use* at end of 2012
- 38% reported having ability to integrate outpatient and inpatient data
- 27% reported having system in place for predictive risk assessment AND risk stratification

Care Management

- 21% reported pre-visit *planning, medication management*, and *reminders* for preventive care
- 32% reported *chronic care mgmt.*
- 20% reported all or nearly all systems in place to ensure *smooth care transitions*
Wright Brothers’ Aircraft

1900

1902

1901

1903
Thank You
kpatel@brookings.edu
## Employer ACO Options Today

<table>
<thead>
<tr>
<th></th>
<th>Pre-Made</th>
<th>Custom-Made</th>
<th>Homemade</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Participate in an ACO already available through the health plan</td>
<td>Create a customized ACO with the health plan</td>
<td>Directly contract with a provider group</td>
</tr>
</tbody>
</table>

**What’s the right fit?**
A well-designed ACO has the potential to deliver higher quality care at lower costs.
High Performance Networks

- Provides adequate continuum of care (e.g. primary care, specialty care, behavioral health)
- Ensures adequate access to care (e.g. emergent care, non-urgent and urgent appointments)
- Promotes consistent delivery of patient-centered care (e.g. willing/prepared for changes in practice structure)
Outcomes-Oriented Measurement

- Total membership (e.g. attributable patients)
- Cost, utilization and quality indicators
- Total spend, PMPM, per admission, and per episode for top 10 services
- Overall reduction in total spend compared to prior year (total savings)
- Average reduction in PMPM compared to prior year (when applicable)
- Break down of total payment distribution of savings
• Coordinates with family/care giver/patient to create individual care plans
• Supports patient shared-decision making
• Accommodates patient’s preferred mode of communication (e.g. language, platform)
Patient Care Coordination

• Establishes a defined process and criteria to determine at-risk patients
• Engages patients identified as at-risk (e.g. proactive outreach)
• Provides patient and care giver support (e.g. educational materials, self-management tools)
• Reports quarterly on patient engagement and intervention
Value-Oriented Payment

- Sets goal of at least 20%* of provider compensation flowing through value-oriented payment methods
- Implements non-payment for “never events”
- Adopts risk adjustment, episode-based payment or bundling, and case rates
Cost Measurement and Savings

- Prospective attribution
- Shared risk payment arrangement
- Reduced FFS payments
- Reduction can be earned back through sharing savings
- Clearly defined cost savings
- Medical cost calculated with case-mix adjustment and after the removal of outliers
- Savings capped at 15%
- Losses capped with a sliding rate (suggested 3 year ramp-up)
Transparency

- Provides information to Participants on:
  - Quality of care at the individual provider level
  - Cost of care at the provider and/or episode of care-level
  - Cost of pharmacy
- Provides claims data, financial performance and quality information to Company on
  - Patient claims data
  - Quality outcomes, patient experience, claims and utilization data
  - Overall spending
  - Savings amount,
  - Methodology for distributing savings to providers within the ACO
- Provides feedback and benchmarking information to Providers on
  - Measures and performance targets for performance-based payment arrangements
  - Performance of individual providers within the ACO to guide referral patterns to highest value providers
• Maintains functionalities to optimize data and care management
• Utilizes performance analytic systems and reporting tools
• Supports sharing data with vendors designated by Company as appropriate
• Agrees not to withhold quality and cost data from statewide or regional public performance reporting initiatives
• Agrees not to require exclusive contracts with physician groups, hospitals and ambulatory surgery centers (ASC)
• Agrees not to prohibit disclosure of price and quality information
ACO Toolkit Provides...

- Guidance to determine your best ACO partner
  - RFI for plans and providers

- Detailed provisions for delivering patient-centered care
  - Contract language

- Recommended evaluation criteria
  - Specific metrics

- Recommended payment criteria
  - Shared-risk with prospective attribution

- Defined quality and utilization measures
  - For benchmarking and performance guarantees
CPR-PBGH ACO Toolkit Components

ACO Toolkit

- How-To Guide
- Provider RFI
- Provider Model
- Contract Language
- Health Plan Questionnaire