Part IV

Pioneer ACOs: If at first you don't succeed…

Pioneer ACO: A Definition

CMS' desperate attempt to "bend the cost curve" and reward high-value Medicare providers by reinventing the HMO without using health plans or capitation.

Why Pioneer *and* Shared-Savings ACOs?

CMS recognition that the Shared-Savings (MSSP) model won't work.

Review: Industry Response to MSSP ACO Proposed Regs

- Overly prescriptive
- Operationally burdensome
- Incentives too difficult to achieve
- Excessive risk for inadequate rewards
- Excessive startups costs
- Risk-adjustment acuity-recognition problems
- Retrospective member attribution
- Excessive quality requirements
- Excessive Minimum Savings Rate
- Impractical member opt-out provisions

i.e., Regs Less Popular Than Congress

Applicants Must Be Providers Structured As:

- ACO professionals* in group practice arrangements
- Networks of individual practices of ACO professionals
- Hospitals employing ACO professionals
- Partnerships or joint venture arrangements between hospitals and ACO professionals, or
- Federally Qualified Health Centers

* Doctor of medicine or osteopathy, physician assistant, nurse practitioner, or clinical nurse specialist

Expectations of Pioneer ACO Applicants

- Extensive experience with care improvement
- Either have, or be able to have payment arrangements with:
  - Financial accountability
  - Performance incentives
- Able to respond very quickly to RFP deadlines
- I.e., No traditional, volume-dependent providers need apply

Defining Characteristics: Pioneer ACOs

Provider Eligibility:

- Competitive 1-time application process—closed mid-Aug 2011
- Providers can't do both MSSP and Pioneer ACOs
- For already integrated, value-based organizations
- 15,000 minimum M'care beneficiaries (5,000 rural)
- FQHCs ok (not w/ MSSP)
- Hospitals may include children's, cancer, CAHs (not w/ MSSP)
- PCPs may include NPs & PAs (not w/ MSSP)
- CMMI wants to limit to 30 Pioneer ACO orgs
- Number of applicants uncertain, but "…quite a bit of interest"

Pioneer Known Applicants (9/15/11)

- Tucson Medical Center in Arizona
- Monarch HealthCare in Orange County, Calif.
- Norton Healthcare in Louisville, KY
- Banner Health (multiple states)
- Mountain States Health Alliance (multiple states)
- Fairview Health Services in Minnesota
- Hackensack University Medical Center in New Jersey
- Montefiore Medical Center in New York
- IntegraNet in Houston, Texas
- HealthCare Partners in California
- Advocate Health Care in Illinois
- Crystal Run Healthcare in New York
- Texas Health Resources
- Park Nicollet in Minneapolis, Minn.
- Detroit Medical Center in Michigan
- Henry Ford Health System in Michigan
- North Texas Specialty Physicians in Fort Worth, Texas
- Maine Health
- Maine General

Conspicuous By Their Absence

- Mayo Clinic
- The Cleveland Clinic
- Geisinger Health System
- Intermountain Healthcare

Defining Characteristics: Pioneer ACOs

Payment:

- Population-based Core Payment Arrangements
- Shared savings/losses
- Complex savings/loss reconciliation calculations
- CMMI open to alternative payment arrangements
- 60-75% risk/reward sharing (50-60% w/ MSSP)
- 1st $ savings/loss sharing w/ 1% gate (2% hurdle MSSP)
- ACO may exclude claims above 99th percentile
- 3-5 ~annual Performance Periods (3 for MSSP)

Defining Characteristics: Pioneer ACOs

Operational Issues:

- Prospective beneficiary assignment (“alignment”)
- Involuntary enrollment—mostly
- Self-assignment for new Mcare, FFS re-enrollees
- Assignment by plurality of PCP/specialty care
- Compliance plan/officer required
- Requires outcome-based contracts for 50% provider revenues by 12/13
- Board to include consumer advocates, patient reps (75% MSSP)
- Similar compliance reqs as MSSP (same quality, antitrust)
- CMMI “Continuous and comprehensive evaluation”

Defining Characteristics: Pioneer ACOs

A Wealth of New Acronyms

CMMI	Centers for Medicare & Medicaid Innovation (formerly CMI: Centers for Medicare & Medicaid Innovation)
MSSP	Medicare Shared Savings Program
PBA	Prospective Beneficiary Assignment
PP	Performance Period
PBP	Population-Based Payment
CPA	Core Payment Arrangements

Core Payment Arrangement

Performance Period	Core Payment Arrangement
1	60% savings/loss share to max 10% of A & B costs
2	70% savings/loss share to max 15% of A & B costs
3	50/50 FFS/PBP (PMPM) if min. 1-5% savings in PP 1 & 2
3 (alt)	Revert to 60% share if no min. savings in PP 1 & 2
4	Only if PBP achieved during PP3. Baseline expenditures reset to new 2011-2013 level
5	Same as 4 but no additional reset

PMPM Population-Based Payment

- Beginning year 3
- Requires minimum 1-5% savings both years 1 & 2
- Axes 50% of FFS rates and payments
- CMS pays the other 50% pmpm to ACO
- I.e., a half-axed form of capitation
- 70% savings/loss sharing continues with PBP
- Thus, PBP subject to potential partial clawback
- Thus, PBP not really a capitation prepayment
- ACO must achieve PBP in PP3 to continue to PP4 & 5

Purpose of Population-Based Payment

- To have three words replace one: capitation
- To overly complicate a simple mechanism: capitation
- To allow ACO to provide additional benefits (??)
- To facilitate ACO infrastructure investments in care coordination (??)
- CMMI open to other, higher risk/reward population-based payment approaches (capitation?)
- Someone may propose something even more complicated and nonsensical than CMS formula, but I doubt it.

Alternative Payment Arrangements

Encourages alternative payment models that include:

1. Escalating levels of financial accountability over time
2. A transition from fee-for-service to population-based payment by 3rd year
3. Savings for Medicare

Core Payment Arrangements and Pioneer ACOs

OPTIONAL VARIATIONS	Performance Period 1	Performance Period 2	Performance Periods 3, 4, 5
Core Arrangement, OR	Up to 60% shared savings and shared losses 10% maximum	Up to 70% shared savings and shared losses 15% maximum	Population-based payment, with up to 70% shared savings and shared losses 15% maximum
Option A, OR	Up to 50% shared savings and shared losses 5% maximum	Up to 60% shared savings and shared losses 10% maximum	Population-based payments as in Core Payment Arrangement
Option B	Up to 70% shared savings and shared losses 15% maximum	Up to 75% shared savings and shared losses 15% maximum	Population-based, up to 75% shared savings and shared losses 15% maximum

http://innovations.cms.gov/wp-content/uploads/2011/07/Pioneer-ACO-RFA.pdf

CMS Termination Provisions

1. Beneficiaries fall below minimum savings threshold >1 Performance Period
2. Failure to meet required quality performance thresholds in performance period 1 or 2.
3. Failure to enter required outcomes-based contracts with non-Medicare purchasers by end of PP2
4. Failure to comply with the physician self-referral prohibition, civil monetary penalties (CMP) law, Anti-kickback statute, other antifraud law, or any other applicable Medicare laws, rules, or regulations
5. If the Pioneer ACO restricts access to necessary care.

Pioneer Best Compared to What?

Most appropriate comparison not with nonstarter MSSP ACOs, but with Medicare Advantage (MA) HMOs.

Medicare Advantage HMOs

- Full capitation, risk/reward sharing
- Full replacement for FFS
- Voluntary member enrollment as option to Medicare A,B,& D
- Savings to Medicare built in (could be done better)
- Positive star-based quality incentives
- Ongoing application process
- Long history
- Substantial enrollment
- Generally successful program
- Requires regulated insurance/HMO entities

Pioneer ACO Advantages over MA

- Less downside risk
- No requirement for state insurance license, capital requirements, regulation…
- …Only in some states

Disadvantages of Pioneer ACOs vs MA

- An experiment w/ many regulatory unknowns
- No assurance of program longevity
- Very short notice to apply (RFA 5/20; LOI 6/30 ; App 8/19)
- Limited to 30 initial organizations
- Complex, involuntary member eligibility determinations
- No beneficiary restrictions on provider choice/utilization
- Lower savings share
- Retrospective savings reconciliation and payment by CMS
- Benefits defined by Parts A & B & supplements
- Excessive cliff-effect quality-compliance measures
- Unknown requirements re MSSP regulation applicability

Disadvantages vis a vis Medicare Advantage

- Retains FFS w/ no formal capitation option
  - 50/50 FFS/PBP doesn't make a lot of sense (apparently forced by MAC claims-payment limitations)
  - 50/50 approach ratchets down in PP4 (the more successful you are, the less successful you can be going forward)
  - No control of out-of-network utilization
  - No ability to do prior notification/authorization in or out of network
  - Claims lag issues including surprises
  - Claims control issues
  - Beneficiary ability to opt out of data identification

Overall Conclusions

- Better than MSSP ACO proposed regulations
- Not as good as Medicare Advantage
- Still trying to reinvent the HMO and capitation without using those mechanisms or terms
- I.e., don't feel bad if you didn't make the application deadline

Next Up –
Monetizing Patient Value: Beyond ACOs

Part V

Monetizing Patient Value: Beyond ACOs

What Is an ACO?

A Strategic Redefinition:

A means for providers to capture savings generated by providing high-value patient care.

Providers, You Know You're a Real Strategic ACO Player If…

- You realize your profit centers are your ACO's cost centers,
- You're moving from a business model that maximizes utilization to one that minimizes it, at least for fixed patient populations, and
- Your financial incentives allow you to thrive because of the above, not in spite of it.

Four Fundamental Problems With American Health Care

- Half of all medical expense is wasted
- Half of all medical care is substandard
- 75% of costs treat preventable disease
- Billing/collection consumes 31%

What is Patient Value?

Value=Quality/Cost

The Good News

Higher quality generates lower total cost.

What is "Quality?"

- Quality = Fitness to satisfy a defined need
- Not an undefined intangible
- Objective measurement of processes & outcomes
  - Standards
  - External benchmarks
  - Internal improvement goals
- Liberal borrowing from others
- Includes everything that affects patient value

How Are High-Value Medical Providers Different?

- Provide high quality medical care…
- At lower total cost…
- Without providing unnecessary care
- With superior customer service
- All delivered to demanding patients who increasingly control *all* the money

Medical Value Opportunities - Examples:

- Hospital overutilization (>10%)
- Nosocomial infections ($28,750 ea)
- Peri-acute readmissions (25% rate @$5,400 ea)
- Over fibrillation (20% @ $25k)
- Sleepy surgeons (83% higher complications)
- Unnecessary imaging (25+% overutilization)
- Patient/Provider price insensitivity

How Many Central Line Catheter Infections Did Your Hospital Have Last Year?

1. 0
2. >0
3. Don’t know

Processes to Improve Value:

- Judicious application of the 80/20 rule
- Relentless pursuit of high quality *and* low cost
- Realization: High Quality = Lower Cost
- Measurement/management of quality /cost metrics
- Continuous improvement

High-Value Medical Provider/ACOs Solve Half of the 4 Problems

- Half of all medical expense is wasted
- Half of all medical care is substandard
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But Not the Other Half

- Half of all medical expense is wasted
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FOR THAT, YOU NEED THE ULTIMATE ACO:
A PROVIDER-SPONSORED HEALTH PLAN (PSHP)

Provider Sponsored Health Plan

- By capturing all the premium…
- You capture all the savings

Provider-Sponsored Health Plans

1. Are you in a provider-sponsored health plan?
2. If not, have you ever been in one?
3. Are you planning to start one?
4. None of the above

Preventable Diseases: 6 Causes

1. Obesity
2. Smoking
3. Alcohol/drug abuse
4. High blood pressure
5. High blood sugar
6. High cholesterol

All individually controllable,

24/7 lifestyle dependent

Who Controls Prevention?

- Doctors have almost none
- Ultimate control is with the patient
- Prevention can't be pushed
- It must be pulled by patient demand
- Requires direct financial incentives
- Only insurers can provide

Prevention Incentives

- ACA allows 30-50% premium rebates/incentives for health risk factor control
    1. Obesity
    2. Smoking
    3. Alcohol/drug abuse
    4. High blood pressure
    5. High blood sugar
    6. High cholesterol
- Provider and other support to assist new patient demands for help

Billing/Collection Cost Reduction

- Convert payments from health plans from FFS reimbursement to value-based payment systems (including "C-word")
- Enables retail provider pricing
  - Upfront patient-pay
  - Simplified patient billing
- Reduce total transaction costs from 31% to 2-3%
- Use savings for higher PCP/hospital comp *and* lower premiums

High-Value Providers/PSHP Resolves All 4 Problems

- Half of all medical expense is wasted
- Half of all medical care is substandard
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Advantages of Provider-Sponsored Health Plan

- Extremely competitive against PPO indemnity plans:
  - Medical quality = Marketing advantage
  - Lower treatment/transaction/preventable costs = Lower premiums
- Capitation rewards value, not volume
- Structural fix for CMS-regulated PCP reimbursement
- Sustainable long-term competitiveness
- Provider control of your own destiny

Strategic ACO Value Chain Value Proposition

Strategic ACO Value Chain	Value Proposition
Level 4: Provider-Sponsored Health Plan	Full Premium Capture w/ retail bundling, 80/20-Optimized Quality/Cost Improvement, Optimized Benefits, Retail Pricing, Individual Prevention Incentives/Support,VB Provider Compensation (e.g., HMO, MA, MMC, Exchange-Based Individual Insurer)
Level 3: Full-Risk/Reward Capitation	Global/Partial Capitation from 3rd Party Payers (e.g., MA Capitated Medical Groups/Integrated Medical Systems)
Level 2: Provider Self-Funded Employee Benefit Plan	Full "Premium" Capture w/ retail bundling, 80/20-Optimized Quality/Cost Improve., Optimized Benes., Retail Pricing, Indiv. Prevention Incent/Support (Provider Employees/Dependents Only)
Level 1: Partial-Risk/Reward ACO	3rd Party Payer Savings/Loss-Sharing Arrangements (e.g., Bundled Payments, Medicare VBPP/ACOs, Medicaid ACOs, Commercial ACOs
Level 0: Fee-For-Service	FFS Medicare, Medicaid, commercial insurance, managed care

Strategic ACO Value Chain Value Proposition

Level	Value Proposition
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Level 1: Partial-Risk/Reward ACO	3rd Party Payer Savings/Loss-Sharing Arrangements (e.g., Bundled Payments, Medicare V... Medicaid ACOs, Com...
Level 0: Fee-For-Service	...Medicare, Me... managed ca...

Why Start At Level 2: Your own ERISA plan?

1. It's already a provider-sponsored health plan.
2. No additional risk beyond what you already accept.
3. It is most likely being undermanaged.
4. It's a major expense; savings can be substantial.
5. It likely enables unhealthy behavior now.
6. Little government regulation.
7. If savings can be demonstrated here, you can do it anywhere.
8. If SCHS can't achieve savings here, how can sell value to others?

Don’t have a self-funded employee health plan?

Strategic ACO Value Chain Value Proposition

Level 4:
Provider-Sponsored
Health Plan

Full Premium Capture, 80/20-Optimized Quality/Cost Improvement, Optimized Benefits, Retail Pricing, Individual Prevention Incentives/Support,VB Provider Compensation
(e.g., HMO, MA, MMC, Exchange-Based Individual Insurer)

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(Provider Employe

Level 1:
Partial-Risk/Reward
ACO

ring Arrangements
PP/ACOs,

Level 0:
Fee-For-Service

FFS Medicare, Medicaid, comme
managed care

Important to Understand

- It isn't easy
- It is doable
- You may have no choice

Next Up –
Politics and the Future of Health Reform