Succeeding with Accountable Care Organizations

The Point B Webinar Series

October 25, 2011
Today’s Discussion

- Key ACO trends and emerging models
- Critical success factors for building an ACO
- Developing your ACO strategy
ACO Definition and Implications

An ACO is a set of providers associated with a defined population of patients, accountable for the quality and cost of care delivered to that population.

- ACOs are “accountable” for specific population spending targets and clinical outcome improvements via shared risk/reward payment models.
- Mindset shift from volume to value.
- Core of an ACO is primary care (e.g., medical home model).
- ACO providers may include primary care physicians, multispecialty groups, and/or hospitals/delivery systems.
- Goal of the ACO is to deliver coordinated and efficient care across the care continuum while slowing growth in overall costs.
ACOs Have Several Important Distinctions from HMOs

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<tr>
<th>Leadership</th>
<th>HMO</th>
<th>ACO</th>
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<tr>
<td>Set by health plans</td>
<td>Set by physicians</td>
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<tr>
<th>Provider Choice</th>
<th>HMO</th>
<th>ACO</th>
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<tr>
<td>Restricted</td>
<td>Voluntary</td>
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<th>Payment</th>
<th>HMO</th>
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<tr>
<td>Risk-based capitation payments</td>
<td>Shared savings/risk with incentives aligned on improved outcomes</td>
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<thead>
<tr>
<th>Care Coordination</th>
<th>HMO</th>
<th>ACO</th>
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<tr>
<td>Fragmented</td>
<td>Coordinated across the care continuum (e.g. medical home)</td>
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<tr>
<th>Risk Management</th>
<th>HMO</th>
<th>ACO</th>
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<tr>
<td>Potential for adverse selection with small risk pools</td>
<td>Larger populations improve risk pooling</td>
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<tr>
<th>Contracting</th>
<th>HMO</th>
<th>ACO</th>
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<td>Health Plan intermediaries</td>
<td>Direct contracting with provider organizations</td>
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The Building Blocks of an ACO

**Patient Engagement**
Bonding patients for the long-term

**Model of Care**
Standardizing clinical coordination across care continuum

**Measurement**
Monitoring metrics and improving processes real-time

**Financing**
Aligning risk/reward for reimbursement

**Technology**
Integrating / optimizing systems and deriving economies of scale

**Organization**
Establishing strong physician leadership and governance
Key Trends Driving the Creation of ACOs

• Unsustainable growth in national healthcare expenditures

• Health reform as catalyst for exploration of alternative payment models

• Preliminary favorable outcomes for Medicare and commercial shared savings (ACO) pilots
  - Medicare Physician Group Practice pilot
    Decrease in spending over 5 years
  - Blue Shield CalPERS ACO
    $15-$20 million cost reduction and 15% decrease in hospital readmissions
  - AHIP ACO Study
    10% improvement in quality and 15% decrease in readmissions and total patient days

• 14% of 228 survey respondents (32 organizations) currently participate in an ACO

• 42% of today’s ACOs cover 10,000 or more lives

• 39% of ACOs planned for the next 12 months will be administered by physicians

Source: Healthcare Intelligence Network e-Survey, Feb. 2011
Emerging Models

**Benefits**

- Independent Physician Association
  - PC base/defined population
  - Ease of governance

- Multi-Specialty Groups
  - Provider alignment
  - Broader IP/OP clinical coordination

- Integrated Health System
  - Provides foundation for population management
  - Care coordination experience
  - IT infrastructure
  - Access to capital

**Challenges**

- Limited clinical integration
- Capital for start-up
- Lack infrastructure
- Alignment with specialty and acute care providers

- Alignment with acute care providers
- Moderate/substantial investment
- Cost to standardize across multiple specialties

- Value-based payment
- Data exchange and care coordination across continuum
- Alignment across primary care and specialty providers

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**Payer**

- PC
- PC
- PC

- spec
- spec

- hosp
- hosp

- hosp
- hosp

- pc
- pc

- pc
- pc

- pc
- pc

- pc
- pc
ACO Payment Evolution

Spectrum of Risk

- FFS
  - Low risk, minimal barriers to entry
  - Maintains status quo with potential upside based on overall savings

- P4P
  - Incentives aligned based on quality metrics
  - Providers assume downside risk if thresholds not met

- Bundled Payment
  - Providers are paid per patient to provide/manage care across continuum
  - Requires robust infrastructure and standardized practices

- Episode Payment

- Partial Capitation

- Full Capitation

- Global Budget

Majority of ACO Risk-Sharing
Providers Will Have to Do More With Less

- Total funding will decrease
- There will be a redistribution of funds among providers
- Primary care will receive a larger portion of funding for preventative care and chronic care management, while hospitals experience decreased payments based on lower volumes
- Specialty spend will decrease due to fewer elective procedures and unnecessary care
# ACOs Will Create Winners and Losers

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<th><strong>Impact</strong></th>
<th><strong>Incentive</strong></th>
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<tr>
<td><strong>Hospitals/Health Systems</strong></td>
<td>• Reduced census • Poor negotiating position with plans if inefficient</td>
<td>• Offset reduced utilization with increased market share</td>
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<td>• Demonstrate efficiencies in care coordination and infrastructure</td>
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<td><strong>Payers</strong></td>
<td>• Left out if employers negotiate directly with ACO</td>
<td>• Higher margins under outcomes based payment structures</td>
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<td>• Decreased leverage with large health systems</td>
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<td><strong>Specialists</strong></td>
<td>• Reduced consults/high-end procedures resulting from improved care management</td>
<td>• Offset reduced visits with increased volume spread over larger population</td>
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<td>• Compensation based on outcomes not volume</td>
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<td><strong>Primary Care Providers</strong></td>
<td>• Increased influence • Responsible for care coordination across providers</td>
<td>• Highest stake in improving patient outcomes</td>
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<td>• Limited resources for start-up investment</td>
<td>• Leadership role for care model</td>
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<td>• Increased revenue through shared savings</td>
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# ACO Critical Success Factors

| Patient Engagement | • Consumer engagement as key differentiator to attracting and retaining patients  
|                    | • Patients bonded for long term with primary care within ACO network |
| Model of Care      | • Primary care base has capacity to manage defined ACO population  
|                    | • Preventive care/chronic disease management programs (e.g. medical home) |
| Measurement        | • Incremental plan to track and achieve best practice quality metrics  
|                    | • Target at-risk patient populations for proactive outreach |
| Financing          | • Understanding of net financial impact of various participation scenarios  
|                    | • Shared financial incentives over time to encourage value-driven care |
| Technology         | • System optimization (EMR, supply chain, revenue cycle, etc.)  
|                    | • Economies of scale through elimination of duplicative systems / services  
|                    | • Integrated systems and clinical data across multiple provider settings |
| Organization       | • Strong physician leadership / governance  
|                    | • Engaged physicians across various care settings in alignment with triple aim objective (improved health, better care, decreased cost) |
ACOs Require Different Thinking

• For now, it’s all about **leverage and scale**
  • Local markets will increase their focus on leverage and scale over the next 12-24 months
  • Provider acquisition/consolidation will be prevalent as players jockey for clinical share to increase leverage and improve financial position

• This is a **chess game** where you need to think three moves ahead
  • Aligning with the right partners will strengthen your market position and provide you with the population base required for long-term viability
  • Doing nothing may leave you on the outside looking in with limited choices

• Understanding and **predicting your local market** is pivotal
  • You must know the market better than, or at least as well as, your competitors
  • It is imperative to understand the bottom line impact of key business drivers under different market scenarios
What Every Provider Needs to Know Now

➢ What is our competitive stance relative to ACOs in the market?
   • Are we a market driver or follower?
   • What actions are our competitors taking?
   • With whom should we partner?

➢ What is our ACO participation strategy?
   • Do we understand the financial impact of various participation and payment models?
   • What level of market share is required to offset expected reduced utilization?
   • What payment model(s) should we actively pursue?

➢ What are our gaps in ACO operational readiness?
   • How does our technology capability stack up relative to the market?
   • Where are our biggest opportunities to improve care coordination?
   • What are our strategies to strengthen patient engagement and build loyalty?
Developing Your ACO Strategy

Getting ahead of the ACO curve by integrating planning, design and execution.
**Planning: Know Your Competitive Position**

*Assess local market trajectory and competitive position by conducting analysis of key internal and external drivers*

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<th>Inputs</th>
<th>Insights</th>
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<tr>
<td>• Internal SWOT analysis</td>
<td>• Market competitive stance</td>
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<tr>
<td>• Demographic and population growth projections</td>
<td>• Local market study outlining trends in demographics, utilization, competition, practitioner supply and demand</td>
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<tr>
<td>• Clinical service line supply/demand</td>
<td>• Competitor analysis and partnership scenarios</td>
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<tr>
<td>• Inpatient/outpatient utilization trends</td>
<td>• Partnership/affiliation targets</td>
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<tr>
<td>• Local market payer mix (e.g. Commercial, Medicare, Medicaid)</td>
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<td>• Competitive environment</td>
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<td>• Key employer groups</td>
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<td>• Market intelligence/research</td>
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Planning: Understand the Financial Impact

Evaluate financial impact of key drivers across ACO participation scenarios

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<th>Inputs</th>
<th>Market Scenarios</th>
<th>Insights</th>
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| • Population age band demographics at county / census tract  
• Service line utilization (e.g. IP Days/1000, PC visits)  
• PMPM medical/non-medical expense trends  
• Provider reimbursement terms (e.g. per diem rates)  
• Facility/physician capacity  
• Financial performance | • ACO population/growth  
• Clinical market share  
• ACO partner integration/participation  
• Provider reimbursement (Medicare & Payers)  
• PC & Specialty utilization volumes  
• IP/OP hospital utilization volumes  
• Shared risk incentives  
• Physician productivity  
• Expense reductions | • What is the necessary market share required to offset loss of IP/OP volumes?  
• What workforce investments are needed to meet estimated demand?  
• What clinical services are required to capture growth by local geography?  
• What is ROI/margin impact across a set of market scenarios?  
• With whom should we partner?  
• What is performance impact of range of shared risk payment models? |
Design: Identify and Close Key Gaps

**Early Stage**
- Patient Engagement
  - Online Health Risk Assessments
  - Web Services
- Model of Care
  - Minimal care coordination
  - Pockets of innovation (e.g., medical home, lean)
- Measurement
  - Provider-centric quality reporting
  - Initial population metrics established
- Financing
  - Net impact scenarios developed
  - 1-Sided risk
  - FFS + Shared Savings Pilots
- Technology
  - EHR Implementation/Stabilization
  - Meaningful Use
  - IT for individual providers
- Organization
  - Fragmented market
  - Provider partnerships
  - Payer/ACO arrangements explored

**Middle Stage**
- Patient Engagement
  - ACO Member Marketing
  - Mobile Services
  - Secure Messaging
- Model of Care
  - Moderate care coordination across various provider settings
  - Predominance of medical home
- Measurement
  - Prevalence of population based quality reporting
  - Patient profiling
- Financing
  - 2-sided risk
  - Bundled payments/partial capitation
  - Reward value-based outcomes
- Technology
  - EMR Optimization
  - Economies of scale across ACO providers
- Organization
  - ACO networks being formed
  - Provider acquisitions/affiliations
  - ACO governance structures / JV

**Advanced**
- Patient Engagement
  - Personalized patient care plans
  - Remote monitoring
- Model of Care
  - Population Management
  - Real-time Care Coordination
- Measurement
  - Predictive models for disease prevalence
  - Real-time outcomes
- Financing
  - Partial to full capitation model with two-side risk
- Technology
  - Broad health data exchange across ACO providers
- Organization
  - Health system consolidation
  - Few systems dominate at a local market level
Summary

• The time is now
  • Drivers of ACOs are not going away
  • Payment based on outcomes will be a critical component of delivery system reform
  • Local markets are already changing rapidly and it is critical to begin planning now

• Providers should focus on
  • Understanding their market to define competitive stance
  • Evaluating financial scenarios to determine risk tolerance
  • Identifying and closing operational gaps

• This is a journey
  • ACOs are a long-term strategy
  • One size does not fit all
Questions?

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