Is there an ACO in your Future?

Massachusetts League of Community Health Centers
Community Health Institute
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Are ACOs/Integrated Care Systems Here to Stay

Why this time is different?

- Health cost pressures magnified by unprecedented economic decline
- Accountable Care Act and Massachusetts Health Reform
  - Access victory established a scorecard on cost!!!
- Recognition of Need to Improve Health Status of Population/Workforce
- Delivery system restructuring and consolidation pressures
- Demise of FFS as viable payment system option

Issues that could Impede ACO/ICS development

- Economic turnaround
- Consumer rejection of care models/benefit design
- Regulation of ACOs (see CMS demo regs!!!)
- Wrong headed governance, lack of partnering among delivery system components of ACOs
Health Centers Partnership Due Diligence

• Goals of Health System
  – Position health system in post health reform world
    • Leadership must develop adopt Integrated Care System (ICS) success as primary focus of organization
    • Investments tied to improving performance measures, coordination of care, and ultimately outcomes
      – Commitment to support evidence based medicine
      – Acceptance of PMPM as revenue metric
      – Recognition that hospitals are cost centers
  – Commitment to align incentives across entire system
    • Realign capital as required
    • Board support for mission focused on improved health status of community, including preventive services and risk reduction for chronic illness
    • Ultimately, payer recognizes ICS as product, positive steerage
Health Centers Partnership Due Diligence

• Integrated Care System builds revenue and market share projections on:
  – Primary care strategy – federal and state definitions of ACO’s all built around model of PCP attribution to one system
    • FQHC’s drive the revenue models in ICS/ACO systems
  – Referral business based on service line capabilities and specialist
    • Specialist may start pressure hospital system for more aggressive pricing to capture business from PCPs affiliated with other systems
  – ICS must incorporate medical home concept, and reward performance based on clinical outcomes, health status improvement, and efficiency
Understanding Each Players Goals

• Goals of Insurers
  – Risk transfer and Medical loss ratio control
  – Price point for new products (Tiered/virtual networks)
    • Anticipating Exchange requirements (1/1/2014)
    • Understanding Exchange/Connector Requirements
  – Leadership views post reform role as service provider to ICS as well as employers and individuals
    • Willingness to transfer portion of administrative budget, as well as medical budget to support ICS success
    • Insurers redefining their role
      – Infomatics – health status measurement
      – Value proposition to employers
        » Cost of poor health
Understanding Each Players Goals

- Employers/Consumers
  - Willingness to adopt policies that focus on improved health status
    - Value based benefit design
    - Direct employee incentives for wellness
    - Willingness to incent usage within the ICS
      - Virtual network with high compliance
    - Consumer (individual/employee) must understand value proposition provided by ICS based product
      - Employee forums to inform and engage patients
      - Exchanges and Insurers assume role in individual market
      - Education materials are coordinated with Health System

- DOES THIS MODEL WORK FOR FQHC’s
Understanding Each Players Role

• Government as Payer
  – Does procurement activity of MMCO lock in under payment?
  – Will Medicaid programs support network compliance and act as educator
  – Does government entity want ICS to be transparent to consumer
    – Medicare FFS

• NOTE: 1\textsuperscript{st} Generation Medicare ACO demonstrations will focus on gain sharing, will not limit access
  – Cost pressure on insurers, employers, and state governments (waivered states) will drive more aggressive models faster than Medicare
    • Innovation Center – Pioneer ACO’s will allow limited networks
Understanding Each Players Role

• Government as Regulator
  – Requirement to develop ICS to manage payment reform
    • Global budgets as rate setting mechanism on providers
    • Global budgets as response to rate setting on insurers
  – Health Systems need to develop interim steps to respond to government regulatory efforts
    • There is tremendous variability in capabilities and performance in health systems, regulatory models that define ACO through rule making and apply to all health systems in a jurisdiction will increase the risk profile for all health systems over time.
      – Experience with Medicare Advantage (Risk selection/adjustment)
Health System Capabilities

- **ACO/Integrated Care System**
  - **IT Systems and Business Support**
  - **Clinical Support**
    - **Physician Organization**
    - **Hospital**
    - **Home Care Rehab Chronic Care (own/contract)**
    - **Key Affiliates**
      - Amb Surg
      - Imaging
      - Lab Services
      - FQHCs (own/contract)
Health System Capabilities

• Key Indicators of Success
  – Does health system currently participate in, and more importantly manage risk based contracts.
    • If not, what percent of revenue is currently tied to performance based agreements
  – Does ICS have capability to measure actuarial costs, develop utilization targets and trend expectations for budget build-up?
  – Does Health System have the capability to convert that pmpm budget into a favorable contract with a payer?
  – Does ICS have the clinical management capabilities to meet and exceed contracted targets?
  – Does ICS have HER / data warehouse / analytics
    • Where is ICS on IT continuum

• Are capabilities scalable and applicable HC environment
Health System Capabilities

• Formal Structures
  – Governance and Management
    • Governance must involve committed hospital, physician, and FQHC leadership
    • Management must have clear lines of authority across the institutional entities that compromise the ICS
      – Achieving performance targets cannot be based on blind faith in aligned financial incentives
        » Participation rules
        » Adoption and acceptance of clinical programs and pathways
        » Payment models, both upside and downside, how is performance payment calculated, how much is passed on, how much is held as reserve, at what level is performance recognized?
Health System Capabilities

- Financial Management
  - Actuarial calculation of budget
  - Business knowledge of insurer services and potential impact on risk pool, including product design, pricing strategy, cost sharing models, market segmentation strategy
  - Risk Management
    - Reinsurance strategy
    - Risk adjustment capability, including retrospective health status review
    - Reserve Strategy (risk based capital concept)
  - Provider pricing strategy
    - Rationalize pricing and margin assumptions across service lines and all controlled entities (focus is impact on pmpm performance)
Health System Capabilities

• Contracting Capabilities
  – Budget adjustments, including trend factors, application and timing or risk adjustment factors, and carve outs to performance liability.
  – Infrastructure payments
    • Support for ICS acceptance of clinical management responsibility
    • Recognition of Health System need for risk based capital reserve (without being cost additive to system)
    • Recognition that both clinical and financial management of ICS require robust IT capability
  – Quality Payment
    • Management of existing high risk populations may not reduce cost trends immediately, but should be rewarded.
    • Define quality gates
    • Reinforce success with consumer report cards
Health System Capabilities

- Contracting Capabilities
  - Insurer Requirements
    - Service Level Agreements, data must move to ICS reliably, settlements timely so they can directly relate to health system performance
    - Notification on all product changes
      - Product changes impact risk selection and potential patient compliance
    - Commitment to preferred status and “branding” in tiered or virtual networks
      - ICS as a product
Health System Capabilities

• Data Management and Reporting
  – Clinical reporting including specific PCP/Specialist management reporting, real time dash boards focused on ICS performance metrics, detailed episode reporting and network compliance and overall referral volume reports,
  – Maintain all current reporting at institutional or practice level
  – Financial (Insurance Reporting)
    • Work with payer (IBNR, as example)?
Health System Capabilities

• Clinical management
  – Dedicated Senior (peer leader) leadership (full time)
  – Clinical Advisory Committees
    • Essential to acceptance of clinical pathways, or disease management models
  – Primary Care Focus
    • Service capability
    • Support for patient centered medical home
    • Recognition of increased values of primary care extenders

• NOTE: Massachusetts Experience
  – Internist accepting new patients 2006-64%, 2007-51%
  – PCP appointments w/in one week 2006-53%, 2007-42%
  – Anticipate these pressures by 2014
Summary/Observations

• Key Questions for CEOs
  – What percent of the medical budget can the ICS control?
    • Why should ICS be better at managing contracted providers than insurers have been?
    • Does ACO have required components, capacity and brand to minimize leakage from system and impact on budget.
  – Is my health system capacity in balance with goals of improved health status?
    • PCP to specialist ratios
    • Open PCP panels and/or growth potential to maintain actuarially sound pools
  – Are Insurers, Employers and Government willing to support and recognize value of primary care as foundational to success?