Executive report on ACO / PCMH Development

SOA Employer Benefit Network

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What you will get today

- Go behind the curtain
- Understand the major forces driving change
  - This time is very different
  - Major transformation is inevitable - regardless of the Supreme Court decision
  - An easy prediction – since actions are already underway for leaders
- Hear about major existing applications at the state level
- Outline opportunities and risks for your clients
- Discuss implications for you as a person and professional
- Hear about support from the Society

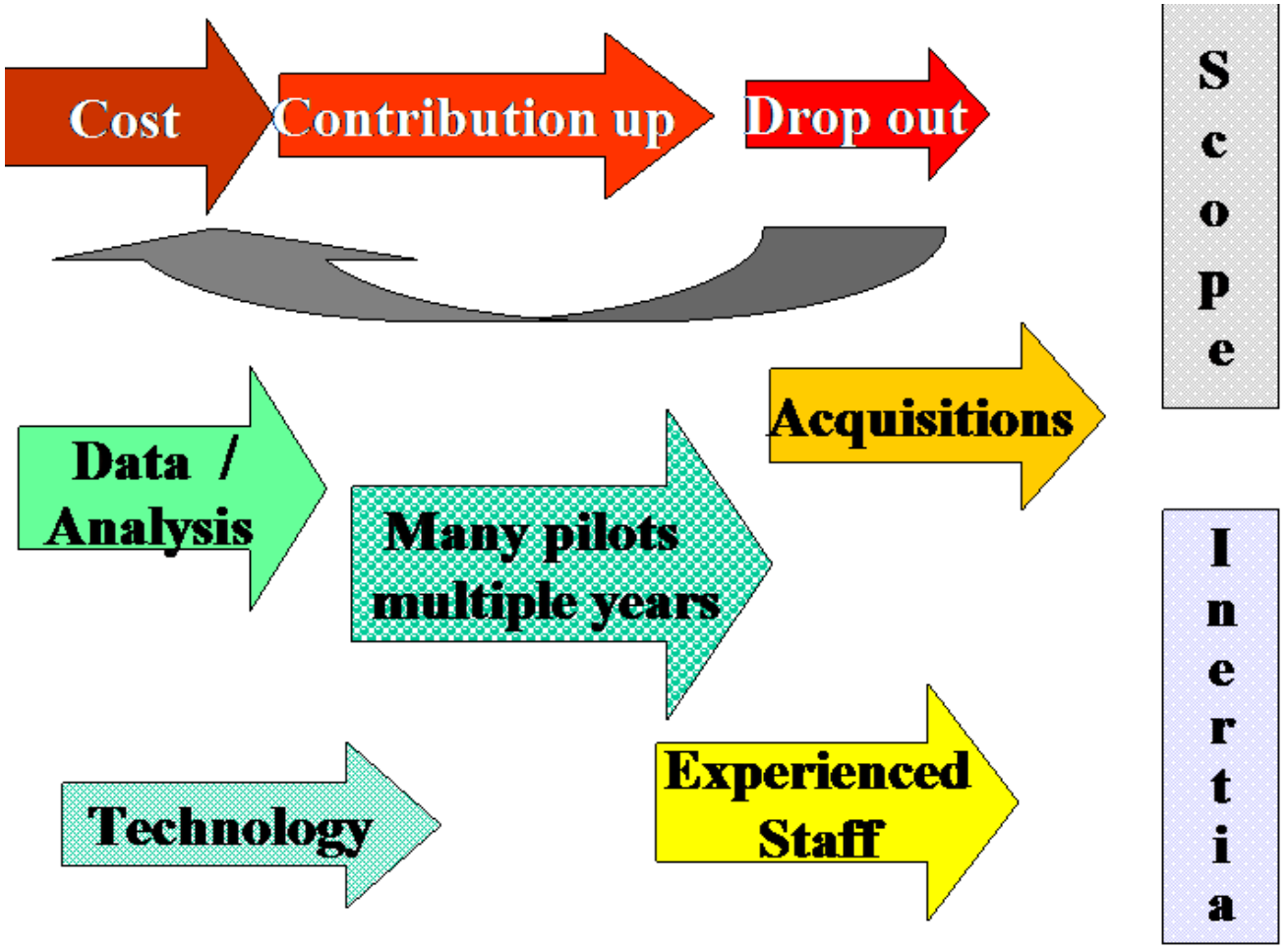
Sources for background

- This is an executive overview; not a basic introduction
- There are many strong sources for the basics
  - CMS website
    - https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html?redirect=/ACO/
  - Presentations from 2011 (spring SOA)
  - Public material from Brookings Dartmouth, major providers and major consulting firms
    - http://www.acolearningnetwork.org/
    - http://www.pcpcc.net/
  - Various major conferences
  - Examples of interesting material is in the Appendix

My background

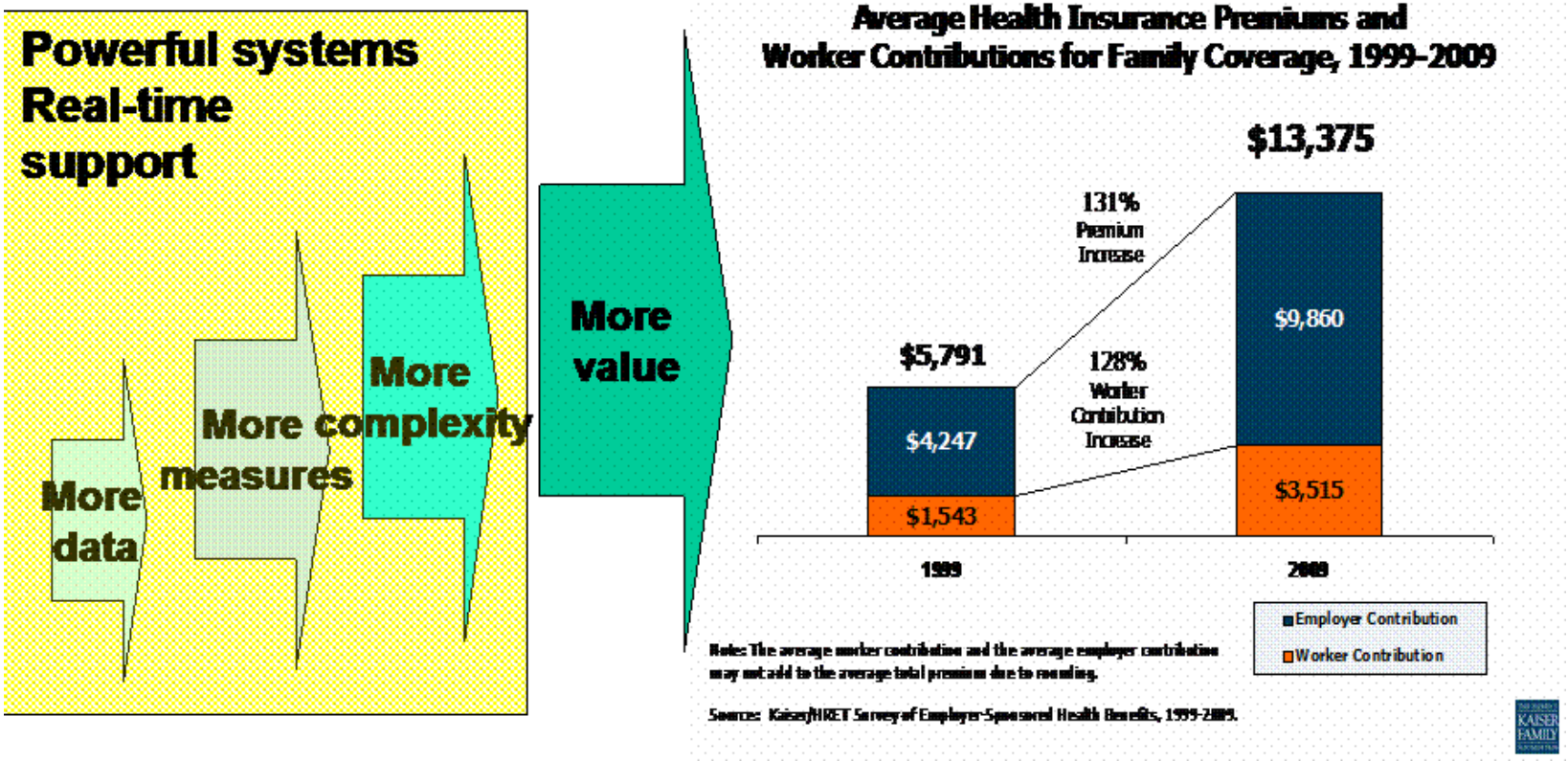
- Decades on high performance networks and ACOs (for employers such as CalPERS through Mercer)
- Previously on Board of Directors for major Independent Practice Association
- Many major recent projects with major physician groups, other providers, and various statewide initiatives.
- Chair SOA Payment Reform workgroup and co-chair comparable group for Brookings Dartmouth

Substantial transformation underway



High costs but new powerful tools

- Late breaking news
  - Family costs $20,278 per year (Milliman)



Major carrier actions

"Starting this summer, WellPoint Inc. which insures some 34 million Americans, will offer primary-care doctors a fee increase, typically of around 10% . . .

The impact could be amplified by another new effort, by health insurer Aetna Inc. which will start paying the 55,000 primary-care doctors across its network an extra fee—of $2 to $3 per patient per month . . ."

http://online.wsj.com/article/SB10001424052970203363504577185270518129952.html

Overview of extensive state activity

- Carrier pilots in multiple locations and major staffing increases
    - Some statewide
    - Some work on high performance and accountability
    - Some merely even more powerful monopolies
- Typically implemented for insured book-of-business and sometimes on a leading client
  - Financial results go to carrier and provider
- Substantive action from leading provider and provider consultants
  - Over a hundred ACOs identified (with probably 80 to 100 in the formal Medicare programs

A once in a lifetime opportunity

(or risk)

We are experts in health cost

We have a responsibility and opportunity to act

Opportunity – major financial potential

- **"The study also showed that specific HMOs—California HMOs in general and group/staff models in particular —were as much as 10% to 15% more efficient than PPOs.**
- **Financial efficiency was not due to age, sex, geography, plan design, or health risk of the population."**
- **http://www.businessroundtable.org/sites/default/files/Hewitt_BRT_Sustainable%20Health%20Care%20Marketplace_Final.pdf**

- **Similar programs are working in other location**

The challenges for employers

- Major progress on quality and information technology
  - Often no advocate for financial results
    - Very uneven results - from 7% savings to higher costs
- Programs are focused on insured or Medicare problems – not self funded employers or your members
- Consolidation for providers can mean major improvement or major monopolies
- From extensive research and personal experience, few programs are ready to meet their financial potential

Opportunity – new class of tools thru provider-based actions

- Much easier contact information
- Physician performance improvement and education
- Extended Disease registries
- High risk / high cost patients
- Clinical management and wellness alignment
- Hospitalist
- Outpatient referral coordination
- Patient channeling (to both outpatient and outpatient)
- Financial incentives – outpatient / hospital / pharmacy
- Advanced pharmacy management
- Physician / hospital integration (and joint expense management)
- Synergy with other programs such as disease and health management

Ongoing role as consultant and actuary

Your roles and actions as a consultant – low

- Client briefing – brief your major client on their main carrier
- Carrier - understand the carrier plan (public references)
- Major Provider – understand the key local provider(s) (public references)
- Leading edge practices – know key powerful initiatives
- Expand existing initiatives, for example
  - On-site clinics can use underlying PCMH concepts

Your roles and actions as a consultant - high

- Affordability and Accountability must be driven by buyers

- Client engagement – link your major client to their main carrier
- Carrier management - get results for your clients
- Catalyst for results – be the employer voice
- Key Provider – meet at least one the key local provider
- Leading edge practices - inventory powerful initiatives through RFI and/or RFP
- Major projects – these are substantive projects – get your share of the dollars

Your role and actions as an actuary
Risk = Opportunity

- Define actuarial role (versus clinical or operational role)
- Data exchange - meaningful and frequent
- Measurement and reporting - deep with modern tools
- Attribution – beyond simple to powerful
- Efficiency discussion can be awkward – facilitate
- Analysis is complicated – use our skills
- Integration rather than monopoly – create results
- Payment reform – actuarial discipline is needed

Professional support

Support for actuaries over coming year

- This conference call
- Payment reform workgroup
  - Ongoing monthly calls
  - Special subgroups
- SOA ongoing webcasts around major concepts and topics
- Academy papers on national reform are released or drafted
- Much larger research budget for health projects
- State Payment Reform Database (SOA)
  - Inventory of over 100 ACO/PCMH programs
- Actions depends whether you will be an active contributor

The long term affordability of the health system has ongoing implications to you, your family, and friends

The pieces are in place;
Time to get your clients involved

Appendix
Samples of major initiatives

A few out of many dozen potential examples

Carrier / physician / hospital alliance

- Hill CHW Blue Shield in CalPERS HMO

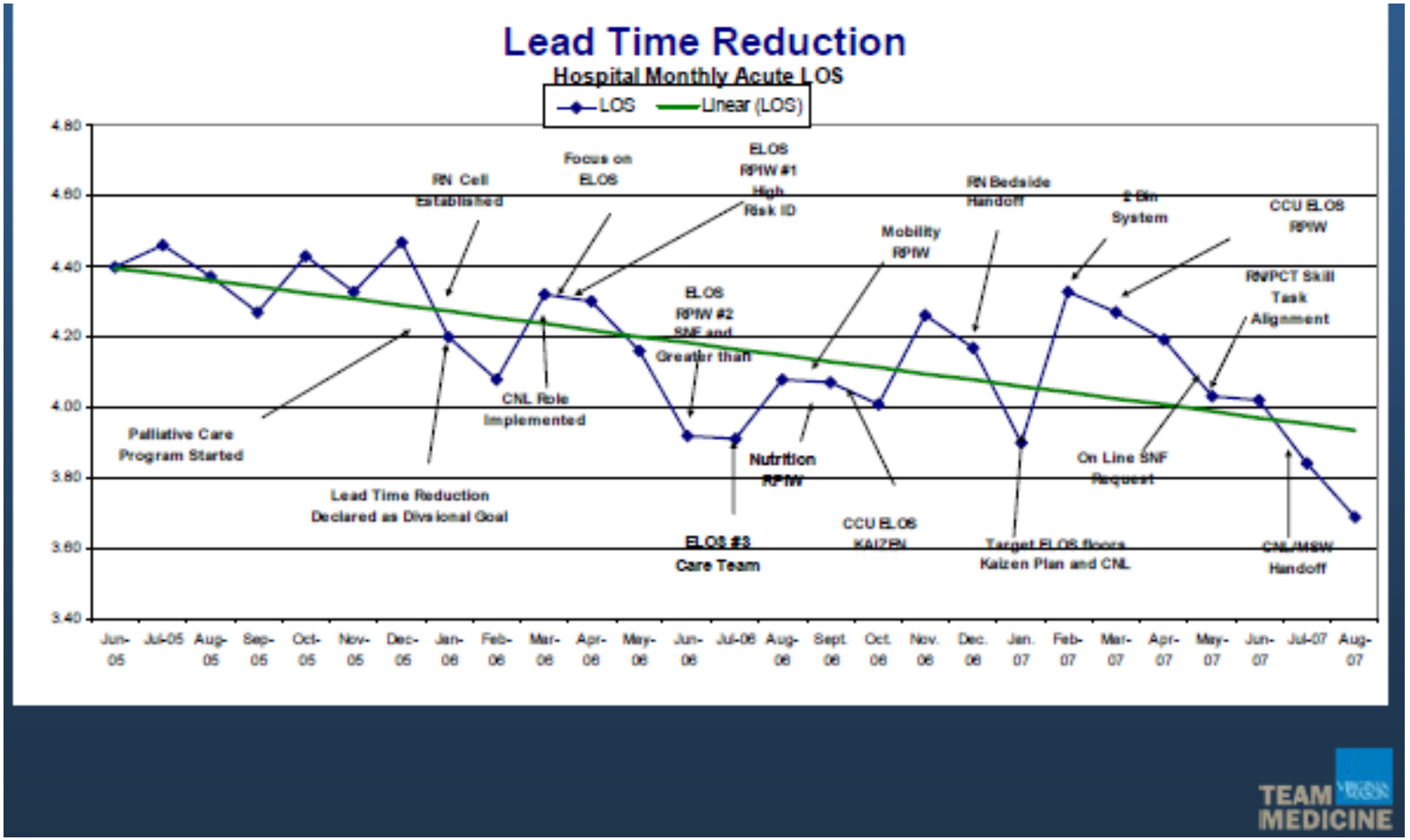
Results from the first year of the pilot showed impressive increases in clinical measurements and cost management, and generated anecdotal feedback from members who felt more actively engaged with their doctor and their own health. The collaboration has succeeded in preventing premium increases, and has achieved an estimated 22 percent reduction in hospital re-admissions and $20 million in savings.

- Strategies
  - Clinical Management
  - Population – Variation and Peer Review
  - Pharmacy
  - IT Integration

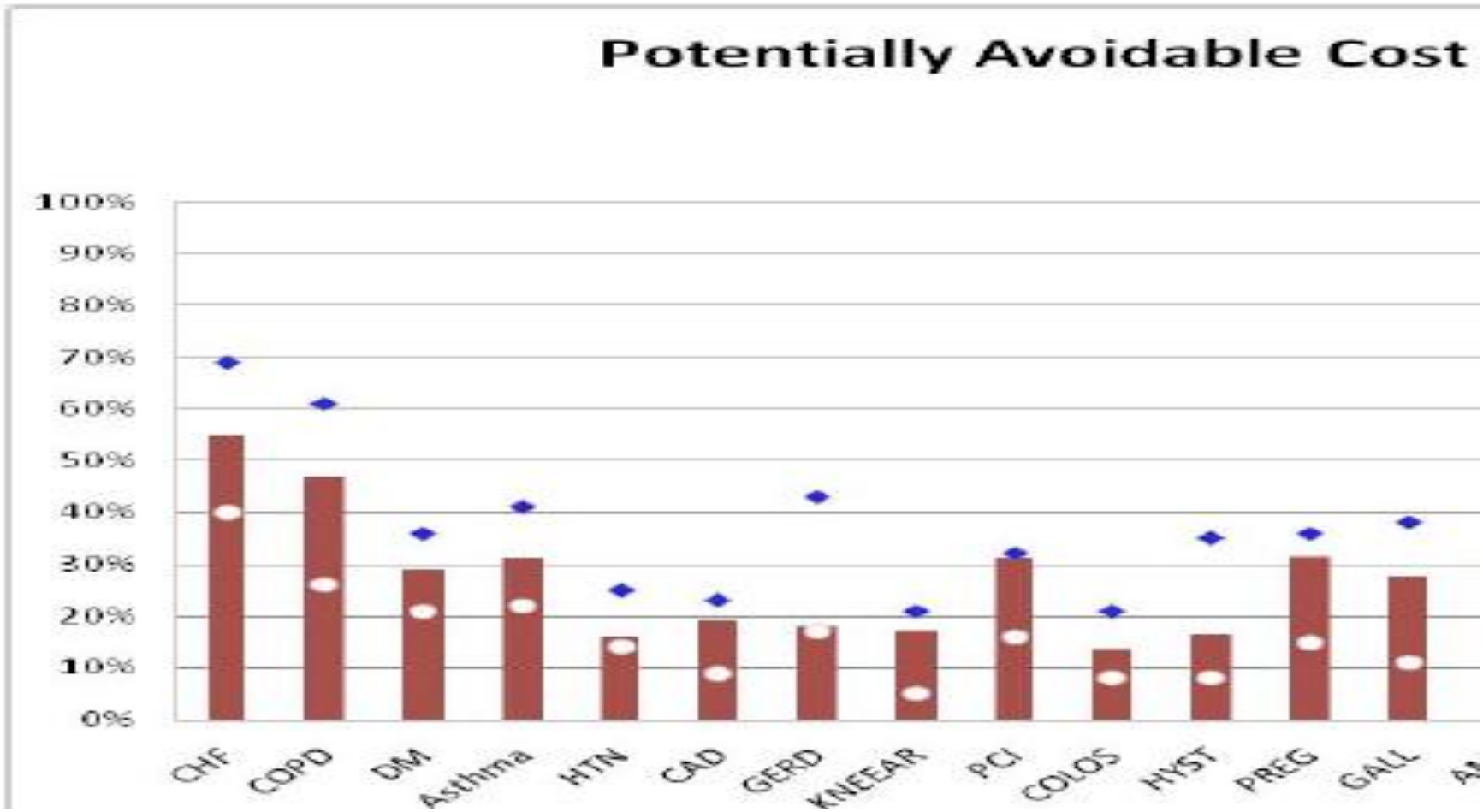
- Preliminary Outcomes
  - 22% reduction in inpatient readmissions
  - .48 day reduction in ALOS (average length of stay) for inpatient admissions
  - 12.9% reduction in inpatient days per thousand
  - 46% reduction in inpatient stays per thousand of 20 or more days

Virginia Mason reengineering

http://www.ehcca.com/presentations/pfpsummit5/kaplan_2.pdf



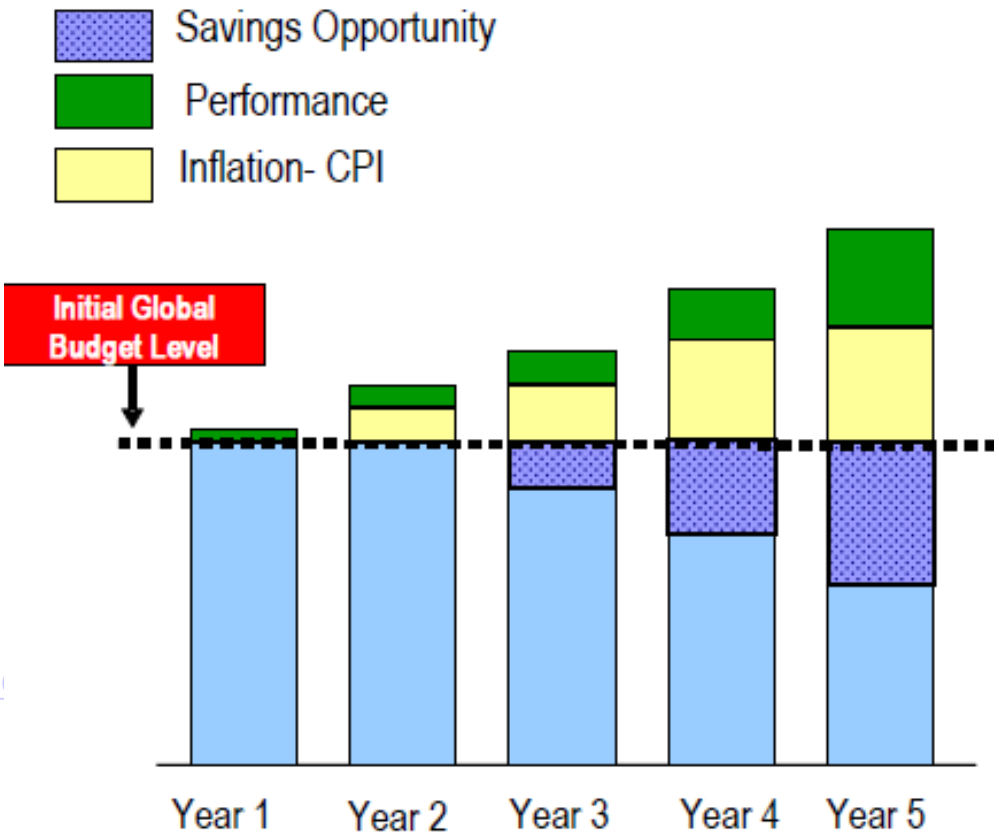
Prometheus – complication reduction



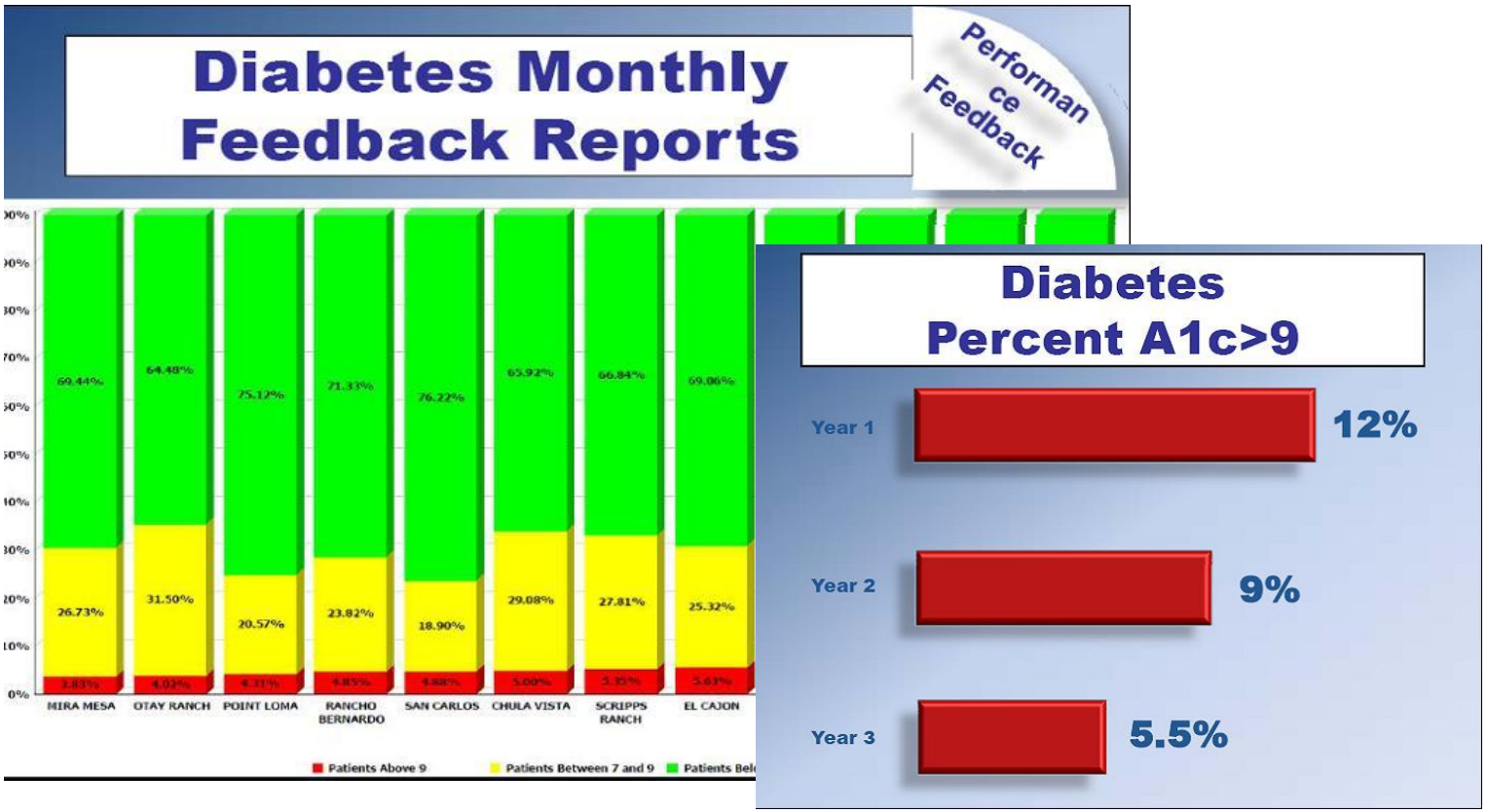
- http://www.prometheuspayment.org/sites/default/files/files/Capital%20District%20Report%209_8_10%20revised.pdf

Alternative Quality Contract – Massachusetts BC

- Global budget
- Quality and safety incentives
  - Up to 10% above global budget
- CPI Inflation factor
  - Controlled and predictable
- http://www.bluecrossma.com/visitor/pdf/alternative-quality-contract.pdf



Physician feedback major health improvement



- Physician example: Right info / right time

2010 CAPG healthcare conference, Sharp-Rees Stealy Medical Group, Dr. Jerry Penso