

ACOs beyond Medicare



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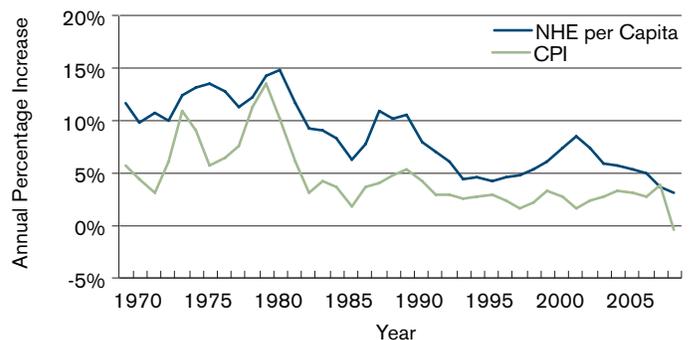
Physicians and hospitals are facing unprecedented pressures from healthcare purchasers to deliver increased value, i.e., higher-quality, more cost-effective care. The authors believe that it will be increasingly difficult for individual providers to continue operating under the status quo and that further provider integration is inevitable. The proposed accountable care organization (ACO) regulations released by the U.S. Department of Health and Human Services (HHS) on March 31, 2011, will make financial success elusive for most of these emerging organizations. For many, a partnership with a health plan will be much more attractive than becoming an ACO serving Medicare fee-for-service beneficiaries.

BACKGROUND

Fee for service (FFS) is the predominant form of payment for healthcare in the United States. The FFS model has few incentives for providers to coordinate care and control costs. Volume is rewarded and providers are often financially penalized for improving the overall efficiency and quality of care if this produces fewer billable units of service. As a result, our healthcare system delivers uneven quality and costs that increase at rates that are significantly above general inflation.

Healthcare costs are eroding business profitability and competitiveness in the private sector and are a primary driver of the fiscal deficits facing federal, state, and local governments.¹ Purchasers are increasingly demanding that costs be held to a more sustainable rate of increase, and providers operating in the FFS environment are facing reductions in fees and an increased administrative burden from complying with programs designed to reduce costs and increase quality. This is having a negative impact on the lifestyles of many physicians, who have to work longer hours to maintain their current income, and many are joining or forming groups to access support and systems that improve the efficiency of their practices.²

FIGURE 1: ANNUAL INCREASE IN NATIONAL HEALTH EXPENDITURES (NHE) PER CAPITA VS ANNUAL INCREASE IN CONSUMER PRICE INDEX (CPI), 1970-2009



Source: National health expenditure (NHE) data from Centers for Medicare and Medicaid Services (CMS), Office of the Actuary, National Health Statistics Group, at <http://www.cms.hhs.gov/NationalHealthExpendData/> (see Historical; NHE summary including share of GDP, CY 1960-2009; file nhegdp09.zip), and CPI data from Bureau of Labor Statistics at <ftp://ftp.bls.gov/pub/special.requests/cpi/cpiait.txt>.

¹ U.S. Government Accountability Office (July 18, 2007). State and local governments: Persistent fiscal challenges will likely emerge within the next decade. Retrieved April 11, 2011, from <http://www.gao.gov/new.items/d071080sp.pdf>.

² Harris, G. (April 1, 2011). More physicians say no to endless workdays. *New York Times*. Retrieved April 11, 2011, from <http://www.nytimes.com/2011/04/02/health/02resident.html>.

WHAT ARE HEALTHCARE PURCHASERS SAYING?

"The outline of the Governor's healthcare cost control reform is very encouraging for consumers, small businesses and taxpayers," said Jon B. Hurst, President of the Retailers Association of Massachusetts. "We should no longer tolerate premium increases which do not reflect the economic realities being faced every day on Main Street or in middle class families across the Commonwealth."

"...the existing fee-for-service payment system is outdated in the medical field..."

"The rate of increase in healthcare costs has outpaced growth in the economy and threatens the financial health of individuals and business..."

Patrick-Murray Administration proposes comprehensive healthcare cost-containment legislation.

—Massachusetts Office of the Governor, February 17, 2011

While the misaligned incentives of the FFS model have been discussed for many years, there have not been serious efforts until recently to overhaul the delivery system so that it delivers better value.

HOW MUCH HAVE WE CHANGED OVER A HUNDRED YEARS?

"That any sane nation, having observed that you could provide for the supply of bread by giving bakers a pecuniary interest in baking for you, should go on to give a surgeon a pecuniary interest in cutting off your leg, is enough to make one despair of political humanity. But that is precisely what we have done. And the more appalling the mutilation, the more the mutilator is paid. He who corrects the ingrowing toe-nail receives a few shillings: he who cuts your inside out receives hundreds of guineas, except when he does it to a poor person for practice. Again I hear the voices indignantly muttering old phrases about the high character of a noble profession and the honor and conscience of its members... As to the humor and conscience of doctors, they have as much as any other class of men, no more and no less. And what other men dare pretend to be impartial where they have a strong pecuniary interest on one side? Nobody supposes that doctors are less virtuous than judges; but a judge whose salary and reputation depended on whether the verdict was for plaintiff or defendant, prosecutor or prisoner, would be as little trusted as a general in the pay of the enemy."

—*The Doctor's Dilemma*, George Bernard Shaw, 1906

Leading up to the passage of the Patient Protection and Affordable Care Act (PPACA) there was lively discussion about provider systems in some parts of the county that consistently deliver high-quality, low-cost healthcare.³ This has led to the notion of holding groups of providers *accountable* for the health and costs of caring for a predefined population or establishing accountable care organizations. This discussion was particularly intense in Massachusetts where many of the PPACA's health insurance reform provisions have been operational for a number of years.

CAN MASSACHUSETTS LEAD THE NATION ON DELIVERY SYSTEM REFORM?

- FFS rewards overuse of services, does not encourage consideration of resource use, and thus cannot build in limitations on cost growth.
- FFS does not recognize differences in provider performance, quality, or efficiency, and thus does not align with evidence-based guidelines or outcomes.

"To promote safe, timely, efficient, effective, equitable, patient-centered care, and thereby reduce growth and levels of per capita healthcare spending, the Special Commission recommends that global payments with adjustments to reward provision of accessible and high-quality care become the predominant form of payment to providers in Massachusetts."

—Recommendations of Special Commission on Healthcare Payment System, Commonwealth of Massachusetts, July 16, 2009

MEDICARE ACCOUNTABLE CARE ORGANIZATIONS (ACOs)

The PPACA's main focus was to improve access to healthcare and little was done to address the cost drivers. However, acknowledging the emerging consensus on the value provided by organized provider systems one of the few provisions that attempt to *bend the cost curve*, was the ACO Shared Savings Program (New Section 1899 of Title XVIII). This mandates the establishment of groups of healthcare providers that have organized into a formal legal structure and that agree to be held accountable for the quality and costs of all care of assigned Medicare beneficiaries in the traditional FFS program.

³ Gawande, A. (June 1, 2009). The cost conundrum—What a Texas town can teach us about health care. *The New Yorker*. Retrieved April 11, 2011, from http://www.newyorker.com/reporting/2009/06/01/090601fa_fact_gawande; Enthoven, A. (Dec. 28, 2008). Health care with a few bucks left over. *New York Times*. Retrieved April 11, 2011, from <http://www.nytimes.com/2008/12/28/opinion/28enthoven.html>; Orszag, P.R. (Nov. 13, 2007). The long-term outlook for health care spending. Congressional Budget Office. Retrieved April 11, 2011, from <http://www.cbo.gov/ftpdocs/87xx/doc8758/11-13-LT-Health.pdf>.

WHY IS CMS ENCOURAGING PROVIDER INTEGRATION?

Motivation for ACOs

- Medicare volume growth unsustainable
- Quality uneven
- Lack of care coordination
- Need a mechanism to
 - Counteract the incentive for volume growth in the FFS system
 - Reward improved quality

–Accountable Care Organizations, David Glass, Jeff Stensland, Medpac, April 9, 2008

This provision has spawned a new industry devoted to helping providers form Medicare ACOs. However, the proposed regulations have serious limitations.

Will the ACO have sufficient financial resources to meet the program’s significant downside risk?

The Centers for Medicare and Medicaid Services (CMS) has stated that it believes an ACO should share in losses if it is to succeed. Under the proposal, an ACO can share in savings or losses from the beginning, or choose *upside only* for the first two years, which would give organizations a chance to gain experience with population management. However, after two years, even an *upside only* ACO will have to share in both savings and losses.⁴

The proposed regulations would also require that an ACO have in place a formal mechanism to pay back losses. CMS would withhold 25% of savings earned in previous years to help ensure repayment of losses.⁵

Will an ACO comprising independent providers serving beneficiaries in an FFS environment be able to replicate the management controls and administrative systems of organized delivery systems?

Systems that are delivering low-cost, high-quality care have significant management oversight of providers and investments in administrative systems to improve care coordination, including electronic medical records, financial management, decision support, and reporting systems. These systems also have physician compensation models that are not FFS-based.

However, many legal challenges exist in a Medicare FFS environment for an ACO to allocate losses and start-up costs among hospital and physicians.⁶

CMS and the Office of the Inspector General are soliciting comments on waivers of the physician self-referral law, the federal anti-kickback statute, and the civil monetary penalties laws’ prohibitions of gainsharing, but it is not clear how an ACO comprising independent providers can effectively implement and finance the administrative systems to ensure success.

Will an ACO be able to manage care with limited data and unlimited beneficiary choice?

CMS proposes to share aggregate data with an ACO. Also, ACOs can request beneficiary-identifiable data, which may include beneficiary ID, date of birth, gender, procedure codes, diagnosis codes, date of service, provider/supplier ID, claim payment type, prescriber ID, drug service date, drug product service ID, and formulary identifier. However, the first time a beneficiary sees an ACO provider, he or she must be offered the opportunity to opt out of sharing this data with the ACO. In addition, beneficiaries would be assigned to an ACO only if the primary care physician (PCP) who provided the plurality of primary care services is affiliated with the ACO. Therefore, the additional data will only be provided for beneficiaries who visit a PCP and who do not opt out of sharing data.

Will high-performing ACOs achieve further reductions in costs?

Savings or losses to an ACO will be based on locally defined benchmarks. The proposed benchmark starts with a weighting of cost for beneficiaries who would have been assigned to the ACO in each of the prior three years. The weighted cost is adjusted for beneficiary characteristics including health status and overall growth in Medicare FFS program costs. The benchmark, in effect, measures past ACO provider efficiency with no adjustment for relative performance.⁷

ACOs whose underlying providers have been inefficient or used high-cost providers such as teaching hospitals will have higher targets than ACOs that operate in efficient environments. It will be easier for the inefficient systems to beat their targets.

A PROVIDER AND HEALTH PLAN PARTNERSHIP

For providers forming ACOs, many of the limitations of the Medicare ACO program can be overcome by partnering with a health plan. A health plan will also benefit from the partnership.

Benefits for providers

- A health plan can provide administrative and financial support until the ACO is sufficiently organized to assume the functions required to better manage care.
- There are fewer legal and organizational difficulties in sharing expenses and allocating financial risk when a health plan is an intermediary between the ACO and its beneficiaries (members).

⁴ §425.5(d)(6)(A) Page 381, §425.7(c)(6) Page 397, §425.7(d)(5) Page 399.

⁵ §425.5(d)(6)(B)(iii) Page 382, §425.5(d)(6)(B)(v) Page 382.

⁶ CMS and OIG Notice and Solicitation of Public Comments on Waivers in Connection with Sections 1899 and 1115A of the Social Security Act; IRS Notice 2011-20 requesting comments regarding the need for guidance on participation by tax-exempt organizations in the Medicare Shared Savings Program through ACOs; Joint FTC and DOJ Proposed Statement of Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program (Antitrust Policy Statement).

⁷ §425.7(a) Page 393, §425.7(b) Page 394.

- A health plan can encourage (or require) member compliance with ACO care coordination and cost management requirements with benefit designs.
- A health plan's contract can provide meaningful financial upside for continued improvement by all ACOs, including those that are already efficient.

Benefits for health plans

- A health plan will have more competitive premium rates if ACOs reduce costs from better care coordination and improved efficiency. This will become even more important if health insurance exchanges allow purchasers to easily compare and shop for health coverage.
- A health plan that can delegate administrative functions to ACOs will find it easier to meet its surplus/profit goals under the new PPACA minimum loss ratio standards.

Commercial population example

Let's examine what this means for a typical commercial population using actuarial models we have developed to measure the benefits and costs of forming an ACO. In Figure 2 we illustrate the utilization and per member per month (PMPM) costs of a typical commercial health plan for an average population when care is delivered by uncoordinated FFS providers.

In Figure 3 we apply the same FFS payment structure (physician fee schedules, hospital payment rates, etc.) on the utilization rates observed from well-organized multi-specialty groups when treating the same population.

Although it is unrealistic to assume that the same FFS payment structure will achieve these results, the difference between *loosely managed* and *well-managed* claim cost PMPMs illustrates the

amount that would be available to share among stakeholders (e.g., increase payments to ACO providers, reduce premium increases, or invest in ACO system improvement). Similar opportunities exist in provider and health plan partnerships in managed Medicare and managed Medicaid.

What can an ACO do while it gains experience?

In many parts of the country, providers are not sufficiently organized to deliver the results illustrated below. However, a health plan can encourage integration among preferred providers with financial incentives and by implementing some of the administrative, healthcare delivery, and reporting functions that the ACOs will require. While these health plan functions can improve the efficiency of independent FFS providers, they fall short of the well-managed results of mature integrated delivery systems illustrated below. As a result, it should be viewed as transition support until an ACO is sufficiently well organized to assume responsibility for all care delivered to assigned beneficiaries (members) under appropriate financial arrangements (e.g., global capitation).

Let's examine the impact and costs of some of the short-term support we would expect a health plan to provide.

Inpatient utilization management

- Medical necessity review for admissions, with admission diversion programs that provide alternatives to hospital admission when medical necessity is not confirmed
- Medical necessity review for length of stay (LOS) and discharge with immediate concurrent interventions when medically unnecessary delays in treatment or discharge are found
- Hospitalist programs focused on reducing medically unnecessary admissions and LOS

FIGURE 2: ACO MODEL, LOOSELY MANAGED

SERVICE CATEGORY	TOTAL UTIL PER 1,000	ALLOWED AVERAGE CHARGE	PMPM CLAIM COST
INPATIENT FACILITY	217.1 DAYS	\$4,140.03	\$74.90
OUTPATIENT FACILITY	1,477 CASES	\$642.65	\$79.10
PROFESSIONAL	13,820 VISITS/PROCED	\$102.41	\$117.94
OTHER	8,189 VISITS/PROCED/CASES	\$110.61	\$75.48
TOTAL MEDICAL COST			\$347.42

FIGURE 3: ACO MODEL, WELL-MANAGED

SERVICE CATEGORY	TOTAL UTIL PER 1,000	ALLOWED AVERAGE CHARGE	PMPM CLAIM COST
INPATIENT FACILITY	161.0 DAYS	\$4,668.82	\$62.64
OUTPATIENT FACILITY	842 CASES	\$653.44	\$45.85
PROFESSIONAL	11,907 VISITS/PROCED	\$89.36	\$88.67
OTHER	7,923 VISITS/PROCED/CASES	\$81.00	\$53.48
TOTAL MEDICAL COST			\$250.64

Outpatient utilization management

- Precertification on certain high-cost outpatient procedures and other services subject to overutilization

Case/disease management

- Management of *frequent flyer* members aimed at reducing emergency room visits
- Post-discharge follow-up with patients aimed at reducing readmissions
- Coordination of care for members with complex problems
- Monitoring of care for patients with high-cost conditions such as transplants or traumatic brain injuries
- Disease management programs targeting members with specific diseases to improve clinical outcomes

Case management and disease management programs improve clinical outcomes but typically do not reduce claim costs much more than the costs of the program.

Physician office support

Until the emerging ACO implements internal physician support systems to improve efficiency, a number of health plan programs can assist with:

- Primary care e-visits to expand patient access to primary care without adding office visits

- Primary care e-consults to reduce specialist referrals
- Urgent care clinics to reduce emergency room visits by shifting care into urgent care centers
- Scope of practice provider incentives to reduce specialist visits by encouraging primary care physicians to expand the scope of their care
- Promotion and implementation of evidence-based guidelines

In Figure 4, we illustrate the possible impact of health plan support on costs using our ACO model. To estimate the costs of each of the programs we used staffing ratios and costs representative of a health plan that is achieving the utilization reductions modeled.

The difference between the *loosely managed* and *post-interventions* claim costs PMPM illustrate what is available for incentives to providers and to reduce premium increases. Also, the *cost of interventions* further illustrates what is available for additional incentives to the ACO when it assumes responsibility for the function.

CONCLUSION

It is increasingly difficult for individual providers to continue without joining a larger integrated system. For many of these emerging systems, a partnership with a health plan will be much more attractive than becoming an ACO serving Medicare FFS beneficiaries.

FIGURE 4: IMPACT ON CLAIM COSTS OF SHORT-TERM HEALTH PLAN SUPPORT

SERVICE CATEGORY	LOOSELY MANAGED PMPM	INPATIENT UM	OUTPATIENT UM	CASE/DISEASE MGMT	PHYSICIAN OFFICE SUPPORT	POST INTERVENTIONS PMPM
INPATIENT FACILITY	\$74.90	(\$8.42)	\$0.00	\$0.00	(\$1.39)	\$65.09
OUTPATIENT FACILITY	\$79.10	\$0.63	(\$1.24)	\$0.00	(\$1.28)	\$77.21
PROFESSIONAL	\$117.94	\$0.01	(\$1.20)	\$0.00	\$0.12	\$116.87
OTHER	\$75.48	\$0.00	(\$0.48)	\$0.00	\$0.00	\$75.00
TOTAL MEDICAL COST	\$347.42	(\$7.78)	(\$2.92)	\$0.00	(\$2.55)	\$334.17
COST OF INTERVENTIONS		\$0.13	\$0.29	\$0.87	\$2.95	\$4.24

APPENDIX: DESCRIPTION OF KEY DATA SOURCES

The results in this paper are based on actuarial models developed to measure benefits and costs of developing an ACO. These models are based on Milliman's 2010 Health Cost Guidelines™ (HCGs). The HCGs consider utilization and average charge levels for roughly 60 benefit categories, and provide utilization and unit cost targets for loosely and well-managed healthcare delivery systems. The HCGs are a cooperative effort of Milliman health actuaries and represent a combination of their experience, research, and judgment. An extensive amount of data is used in developing the HCGs and that data is updated annually.

Loosely managed delivery systems represent systems that do not apply any care management processes that reduce utilization levels.

The loosely managed benchmarks discussed throughout this paper were calibrated to the Milliman Medical Index™ (MMI). The MMI examines key components of medical spending and the changes in these components over time. The MMI incorporates proprietary Milliman studies to determine representative provider-reimbursement levels over time, as well as other reliable sources, including the Kaiser Family Foundation/Health Research and Educational Trust 2008, Annual Employer Health Benefit Survey (Kaiser/HRET), to assess changes in health plan benefit levels by year. The MMI includes the cost of services paid under an employer health benefit program, as well as costs paid by employees in the form of deductibles, coinsurance, and copayments. The MMI represents the total cost of payments to healthcare providers, the most significant component of health insurance program costs, and excludes the

non-medical administrative component of health plan premiums. The MMI includes detail by provider type (e.g., hospitals, physicians, and pharmacies), for utilization, negotiated charges, and per capita costs, as well as how much of these costs are absorbed by employees in the form of cost sharing.

The MMI assumes an average benefit plan for 2010, including an in-network deductible of \$535, various copays (e.g., \$75 for emergency room visits, \$22 for physician office visits, \$10/25%/30% for generic/formulary brand/non-formulary brand drugs), coinsurance of 15% for non-copay services, etc.⁸

The well-managed benchmarks represent average nationwide utilization levels in high-performance managed care environments that effectively apply care management principles across the entire continuum of medical care.

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⁸ 2010 Milliman Medical Index (May 2010). Retrieved April 20, 2011, from <http://publications.milliman.com/periodicals/mmi/pdfs/milliman-medical-index-2010.pdf>.

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