OLIVER WYMAN HEALTH

The business of transforming healthcare

ACOS: DESIGNING VALUE-BASED SYSTEMS THAT WORK

Our team shares effective accountable care strategies for sustained quality, real cost savings, and improved patient experience

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4 TAKEAWAYS:
WHAT PROPOSED MSSP CHANGES MAY MEAN FOR ACOS, INTENDED OR NOT

by Bruce Hamory, Chief Medical Officer, Oliver Wyman

In January 2016, CMS published proposed changes to the Medicare Shared Savings Program (MSSP), including modifications to how accountable care organizations' cost benchmarks are re-calculated each year. If finalized in its current form, ACOs could see some big changes coming. Oliver Wyman's Chief Medical Officer Bruce Hamory, with Engagement Manager Lucy Liu and our Provider team, offers a perspective on the implications, intended or otherwise:

1. REGIONAL BENCHMARK APPROACH HELPS EXTEND SUSTAINABILITY OF THE PROGRAM AND GREATER INCENTIVES FOR STRONG PERFORMERS MAKE IT MORE FAIR OVERALL

- The region-based model is a significant change to the program, and one that we believe will be valuable in ensuring the ongoing viability of the MSSP program. Rather than the current model, where ACOs must continually beat their prior year performance (which can become increasingly difficult if not unsustainable for top performers), the regional approach starts the transition to a county-level rate.
- The proposal calls for an ACO's second- and third-year benchmarks to be re-calculated using not only the national FFS cost trend, but also regional FFS cost trends. Regions will be defined by counties, similar to Medicare Advantage and the Physician Group Practice demonstration sites. The second year re-basing will be 65%/35% national/regional; the third year will be 30%/70% regional.
- This means that the methodology sets the county rate using all beneficiaries in the county eligible for ACO assignment, so two ACOs operating in a given county would receive the same rate. For stronger performing ACOs, this creates larger incentives each year from beating the benchmark. If you're great, your better odds compound each year. If you're a low performer, and part of that is because you're in a high growth region, your benchmarks become a little more forgiving. This further levels the playing field for external local factors that drive trend higher or lower, much of which is out of the immediate control of the ACOs.

2. NON-UTILIZERS ARE FINALLY TAKEN OUT OF THE EQUATION

- The proposed changes would set FFS benchmarks based on only beneficiaries eligible for ACO assignment, rather than all beneficiaries – effectively excluding the low- and non-utilizers who never see a PCP.
- As Niyum Gandhi, Chief Population Health Officer at Mount Sinai Health System, explained, "While a $10K patient might inflate to $11K, $0 always inflates to $0," which was making the performance benchmarks highly stringent.

3. HIGH-PERFORMING ACOS WITH LARGE POPULATIONS MAY BE PRESSURED

- Regional cost benchmarks will be based on all Medicare beneficiaries in the county, so all ACOs in that county have the same regional trend applied.
- CMS determined that since most ACOs' assigned populations are far smaller than the overall FFS beneficiary population, this approach was preferred to customizing each regional benchmark by removing each ACO's own beneficiaries. However, for a dominant ACO that makes up a large proportion of its region's population, this methodology does not give the ACO due credit for its role in bringing down regional costs.

4. ACOS WILL START TO BEHAVE MORE LIKE MA PROVIDERS

- Under the new rules, an ACO's regional trend would be calculated using any counties where at least one beneficiary resides – and the median ACO spans eight counties.
- Where your patients live starts to matter. If you get a patient from a county with higher cost trend, your benchmark trend will be more forgiving if more of your patients live in counties with high cost trend rather than lower cost trend. It might discourage ACOs from serving rural counties, where inflation tends to rise more slowly.

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ABOUT THE AUTHOR

BRUCE HAMORY

Chief Medical Officer, Oliver Wyman

Bruce is a Partner and Chief Medical Officer in Oliver Wyman's Health & Life Sciences Practice. He is a nationally known speaker on the topic of redesigning health delivery to improve value by improving quality and reducing costs.

ACO BUZZ:
CMS RESULTS SHOW PRACTICE (ALMOST) MAKES PERFECT

by Bruce Hamory, Chief Medical Officer, Oliver Wyman

The Centers for Medicare & Medicaid Services (CMS) issued in August 2015 the 2014 quality and financial performance results for Medicare Accountable Care Organizations (ACOs). According to the results, the 20 ACOs in the Pioneer ACO Model and 333 Medicare Shared Savings Program (MSSP) ACOs generated more than $411 million in total savings in 2014. At the same time, 97 ACOs qualified for shared savings payments of more than $422 million by meeting quality standards and their savings threshold. Our Chief Medical Officer Bruce Hamory, with Engagement Manager Bryce Bach, explains that while ACOs are becoming more successful, challenges remain:

Performance year 2014 saw an improvement in total savings, total payments, and most quality measures for participants in MSSP. While major changes are required to make CMS ACOs sustainable, the program is gaining momentum and the opportunity for cost and quality improvement is seemingly validated.

Moreover, as commercial payers and state Medicaid programs move more people into population-based payment systems, the needed scale to support infrastructure investments and changes in care models applicable to all patients and members is being created. And plenty of opportunity still exists for new entrants. Current ACOs cover less than 20% of the Medicare population, leaving ample playing room for other would-be program entrants.

Yet, many ACOs are struggling to shift to new clinical models. Some 46% of MSSP ACOs performed worse than their estimated benchmark and generated “excess expenditures” of $680M. Based on the reports available, some of the individual repayments could have exceeded $10M. Fortunately for these ACOs, all of them are Track 1 and will not need to write checks to CMS for this year. However, the time for them to adjust their care parameters and processes is passing rapidly.

Three Pioneer ACOs are not so lucky and will have to pay CMS a combined $9M for losses incurred. This highlights how difficult it is to make the transition from fee-for-service to fee-for-value, and may potentially define the lower reimbursement levels at which a results share arrangement is no longer feasible. Depending on the exact circumstances locally, a shift to Medicare Advantage and full capitation could be required to ensure economic viability.

Notably, ACOs in previously unmanaged areas, such as Boston, are having more success than in other areas. Among five Pioneer ACOs in the metropolitan Boston area, four achieved substantial share payments ($1.7M to $13.2M), while others in lower cost areas owed money. Boston has one of the highest Medicare payment rates in the US, and the single entity not receiving a payment is the newest entrant into that market. The trend of savings over the next few years in this market will be instructive to the global model.

The difference between success and failure is hinging most instructively on three variables: infrastructure, leadership, and time to mature. Practice, the data indicates, does indeed improve performance. As does commitment. Many organizations are still struggling, underinvesting, and largely still experimenting. There are organizations, however, that can provide a roadmap to successfully moving the whole model for all populations.

Cornerstone Health Care, based in High Point, North Carolina, was one of the few providers that earned a bonus. Here's how CEO Grace Terrell describes Cornerstone's approach:

Two other organizations that have shown commitment to a full pivot and are on an upward trajectory include Colorado's Catholic Health Initiatives and Peoria, Illinois-based OSF HealthCare, where substantial redesign efforts have been applied around areas from analytics to primary care and care management, palliative care, and home health. Our team has identified many other examples of where the reality of value-based health has actually held true to its promise of sustained quality, real cost savings, effective trend management, and improved patient experience.

With the time required to get all the pieces together for successful participation in population health, provider systems should proactively evaluate their regional market conditions and begin to implement those elements that build the foundation for

Cornerstone believed that deeper change was essential at the clinical and operational levels. We completely redesigned central elements of patient care delivery: staffing, care team roles, physical layout of the practice, policies and procedures, and patient engagement methods – with a relentless focus on improving patient outcomes. Our approach was rooted in developing new models of care for targeted patient populations: those at high risk for poor health outcomes and high costs in the traditional fee-for-service payment system. We confronted the thorny organizational issues of incentives and culture and were challenged to keep all of our practices advancing toward a value agenda. To achieve a gain share through MSSP, we had to beat a very low benchmark (since Cornerstone was a relatively low cost medical group to begin with). Ultimately, we will need to shift to more full risk-models to reap the rewards of our progress and innovation.

population health management, while also facilitating success in the fee-for-service world. In some areas, there may be a "first mover advantage."

Additional guideposts gleaned from the CMS results report include:

- **Sizeable savings are achievable even at smaller scale.** Twenty of the 92 ACOs earning savings payments had <7K lives. However, even though the shared savings were positive, the total dollars earned were small, and may not have been enough to cover the ACO's operating costs.

- **Anecdotally, savings are achievable even in rural areas and among ACOs starting at higher levels of efficiency.** Information provided by Oliver Wyman clients suggests MSSP participants in both rural and urban areas can perform well, and some ACOs with quite low starting benchmarks have still earned sizeable payments.

- **Lack of information technology can cost money.** Of the 11 ACOs that were "unable to report quality data," seven had saved a total of $45M and forfeited any of those savings on that basis alone. The remaining four were in a loss position.

- **The economics are still difficult.** The average sharing rate (the portion of generated savings/losses that the ACO gets back as a shared risk payment) of the MSSP ACOs earning payments was 44% and the average sharing rate of the Pioneer ACOs earning payments was 62%. It's very difficult to make these programs profitable for providers at these levels, and we expect to see some of those performing well thus far moving into Track 3 or Next Generation ACO to gain access to higher share retention and prospects for better cash flow mechanisms, among other perks.

- **In view of the recent decision to implement "mandatory" joint replacement bundles is there a point at which HHS decides to try a similar approach to an MSSP?** This is a major unknown and is unpredictable given the fluid political situation. However, given the rapid movement of commercial payers into this arena, the question may be moot.

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ABOUT THE AUTHOR

BRUCE HAMORY

Chief Medical Officer, Oliver Wyman

Bruce is a Partner and Chief Medical Officer in Oliver Wyman's Health & Life Sciences Practice. He is a nationally known speaker on the topic of redesigning health delivery to improve value by improving quality and reducing costs.

PAYER-PROVIDER PARTNERSHIPS: THE FUTURE OF INSURANCE PRODUCTS

by Tomas Mikuckis, Principal, Oliver Wyman

Some of the most compelling health insurance products being launched today are based on a partnership between a payer and a provider. Oliver Wyman's Tomas Mikuckis, with the health services team, explains in a new report "Payer-Provider Partnerships: The Future of Insurance Products" why partnered products matter—and how both healthcare providers and payers can make them a core part of their strategies:

The concept of a health insurance product built around a single provider system, multi-specialty group, Accountable Care Organization (ACO), or Clinically Integrated Network (CIN) may still be in its infancy, but it has already proven its worth. These "partnered products," as we think they should be called, may look at first like little more than just another flavor of a traditional narrow network. But in fact they are much more. The single system dynamic creates the opportunity for deep partnership around the clinical and financial model, member experience, and marketing that a multi-system approach cannot provide.

Some of the early-mover partnered products have been strikingly successful:

- In New Hampshire, **ElevateHealth**, developed by Dartmouth-Hitchcock, Elliot Health System, and Harvard Pilgrim, is achieving cost savings of 15 to 20 percent and passing them on to its customers in the form of lower premiums.
- **Align**, a partnership between Kaleida Health and Blue Cross Blue Shield of Western New York set out to wrap a health plan around a clinically integrated network and lower costs by at least 6 percent.
- **Innovation Health**, a partnership between Inova and Aetna, has developed commercial and Medicare Advantage HMO and PPO products in Northern Virginia, as well as self-insured group products. The first year of product launch in 2013 was a success, achieving growth of 140,000 members.
- We could cite many more success stories, and based on Oliver Wyman research, value-based product partnerships are accelerating, having doubled in last two years and growing at an annual rate of 48% since 2012. Yet we still encounter payers and providers that balk at the idea of partnered products. Payers tend to regard ACO or CIN productization as too complex a process to be rolled out broadly, requiring near-perfect clinical partners, exclusive (or at least first-mover) relationships, and an

unachievable level of collaboration. Providers, for their part, share similar concerns about selecting the right partners—or finding a way to negotiate with payers that doesn't fall into familiar, unproductive, antagonistic patterns.

There may have been reason to feel this hesitancy two or three years ago, when payers and providers alike were uncertain about how partnered products differed from traditional narrow network products and few players had experience in solving the challenges they pose. But now Accountable Care Organizations (ACOs) – and CIN-based products have become more sophisticated and the problems are much better understood. In our work with both payers and providers, we have seen an emerging consensus on how to build, market, and manage partnered insurance products. Productization is becoming a transformation tool that can and should be used by a much broader group of ACOs and CINs than would have been practical only a few years ago.

Learn more about how partnered products create value and how to successfully structure a partnered product arrangement in our full analysis here.

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ABOUT THE AUTHOR

TOMAS MIKUCKIS
Principal, Oliver Wyman

Tomas advises senior executives on consumer engagement and retail strategy, value-based healthcare, organizational transformation, and predictive modeling and risk-based analytical approaches to strategy and decision-making.

ANALYSIS: WHAT SEPARATES SUCCESSFUL ACOS FROM THE PACK

by Patrick Barlow, Partner, Oliver Wyman

Oliver Wyman Partner Patrick Barlow centers his strategy work on helping organizations drive success in their value-based health initiatives. Below he offers his perspective on why some Accountable Care Organizations (ACOs) have failed to generate anticipated cost savings while others are moving forward:

CMS recently announced a bold pledge to drive 50% of provider payments into value-based models, such as ACOs, by 2018. Likewise, a private sector consortium known as the Health Care Transformation Task Force, consisting of a number of large health plans and provider systems, further upped the ante by setting a target of moving 75% of their businesses into value-based arrangements by 2020. These highly visible commitments confirm that healthcare's transformation to value is not only here to stay, but is accelerating.

However, the distribution of this transformational effort remains uneven. While there are some notable progressive leaders driving real change in the market, my team's observations of the value-based healthcare landscape over the past few years suggest that many entrenched players have favored style over substance, making only token efforts towards value. In a rush to keep pace with market buzz, many traditionally-minded payers and providers scrambled to stand up nominal ACOs and issue press releases signaling that they too were in the value-based game. Several years (and millions of investment dollars) later, many of those same organizations struggle to highlight any real transformation.

There are wonderful examples where the reality of value-based health has actually held true to its promise of sustained quality, real cost savings, effective trend management, and improved patient experience.

– Oliver Wyman **Partner** Patrick Barlow

Behind closed doors, many health plan and health system executives admit that their ACOs have failed to generate the anticipated cost savings, and in many cases ANY savings at all. However, there are wonderful examples where the reality of value-based health has actually held true to its promise of sustained quality, real cost savings, effective trend management, and improved patient experience. As we looked at these success stories, a few common themes emerged, separating them from the pack:

- Providers agree to take downside risk, either as a form of capitation or two-tailed risk sharing
- Risk-bearing entities have an active plan to expediently migrate their entire book of business into value-based arrangements
- Providers have a robust financial understanding of how to successfully shift to value, and a willingness to tackle the disruption required to cannibalize existing profit centers (e.g., procedural specialties) before new ones are fully built
- There is a visible and active clinical leader (or leaders) who can drive cultural change around care delivery and champion organization-wide transformation, rather than allowing population health to be a sideline "experiment"
- Physician compensation models are focused on value creation, rather than traditional production, and line physicians share in value-based success
- Value-based models are actively commercialized and productized to drive member volume, capture market share, and build brand and reputation
- Benefit designs and network models that create strong motivation for members to stay within organized care systems

When these elements come together, value-based models have been shown to produce enhanced quality, a differentiated patient/member experience, and measurable financial savings. With leadership from CMS, consortiums like HCTTF, and progressive payers and providers, transformation success stories will continue to multiply. Will this latest push help catalyze the market towards a more complete transformation to value, or will the traditionalist organization continue to set the pace of change?

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ABOUT THE AUTHOR

PATRICK BARLOW

Partner, Oliver Wyman

Patrick's primary areas of focus are corporate and business unit strategy for health plans, health service companies, pharmacy benefit managers, and provider organizations. Much of his strategy work centers on helping organizations drive success in their value-based health initiatives.

ABOUT OLIVER WYMAN HEALTH

Oliver Wyman Health is a virtual community of innovators convened by the Health & Life Sciences practice of global management consulting firm Oliver Wyman.

As the healthcare world changes and leaders look for direction, guidance, and new ideas, Oliver Wyman Health offers a digital platform for diffusing proven value-based solutions. Our in-house team of experts as well as a range of external thought leaders provide practical insights on the business challenges of transforming healthcare from volume to value.

We invite you to share ideas and infographics, contribute novel approaches to the financing and delivery of healthcare, subscribe to receive updates on effective strategies, and connect with other healthcare industry professionals.

Contact Oliver Wyman Health Editor at OWHealth.Editor@oliverwyman.com

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