Accountable Care Organization for the Commercially Insured Population: From HMO to PPO?

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Overview

- What’s at stake?
- The Medicare MSSP and Pioneer proposals
- Lessons from HMO to PPO
- ACOs for the commercial PPO population
  - Organizational size and structure
  - Payment methods
  - Financial solvency regulation
  - Care management
“Accountable Care Organization for PPO Patients: Challenge and Opportunity in California”

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What’s At Stake?

- Care coordination and other ACO principles have been applied to commercial HMO products in California, but enrollment is shifting to PPO products.
- Health plans and medical groups have thrived within Medicare Advantage in California, but most enrollment remains with traditional Medicare FFS.
- PPO and Medicare FFS emphasize patient choice (of provider and treatment) over care coordination.
- The future lies in a creative blend of care coordination and patient choice: How can we make this work?
# Declines in HMO Enrollment in CA, 2004-2009

<table>
<thead>
<tr>
<th>Insurance Type</th>
<th>All HMO Insurance¹</th>
<th>Commercial HMO</th>
<th>Kaiser²</th>
<th>Medi-Cal HMO/Healthy Families</th>
<th>Medicare HMO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Group HMO Enrollment, 2004</td>
<td>15,577,370</td>
<td>6,644,280</td>
<td>6,461,779</td>
<td>2,305,290</td>
<td>720,800</td>
</tr>
<tr>
<td>Medical Group HMO Enrollment, 2009</td>
<td>15,718,350</td>
<td>5,311,850</td>
<td>6,659,879</td>
<td>3,148,400</td>
<td>814,400</td>
</tr>
<tr>
<td>Percent Change in Medical Group HMO Enrollment, 2004-2009</td>
<td>1%</td>
<td>-20%</td>
<td>3%</td>
<td>37%</td>
<td>13%</td>
</tr>
</tbody>
</table>

¹This column does not equal the total of the ensuing columns due to the use of a different data source for Kaiser enrollment data.
²Kaiser includes all enrollees in Permanente Medical Groups, regardless of insurance type; these enrollees are not included in the other categories of insurance.

Data Sources: Cattaneo and Stroud, “#7: Active California Medical Groups by County by Line of Business, for Years 2004 through 2010, Sorted Alphabetically,” May 1, 2010. Provided by W. Barcellona, July 27, 2010; and the Department of Managed Health Care’s Health Plan Financial Summary Report Tool (http://wpso.dmhc.ca.gov/flash/).
Who is to Lead?

- Medicare has the scale but it is hobbled by administrative inertia and lobbying
  - It must find a framework that works everywhere in the nation, despite huge differences in provider organization
  - It imposes/mandates; it does not negotiate
  - It must make sure there are no visible losers
- Commercial health plans and providers lack the scale but have more flexibility
  - Different frameworks for different players
  - Negotiation rather than mandate
Medicare’s Shared Savings Program ACO Initiative

- One- and Two-Sided Risk Models
- Organizational Requirements
- Beneficiary Assignment
- Savings Benchmarks
- Quality Measurement and Reporting
Medicare’s Pioneer ACO initiative

- An accelerated pathway to forming an ACO for providers who already have experience in coordinating care.
- Allows these advanced provider groups to move more rapidly from a shared savings to a population-based payment model (aka capitation)
- Framework will rely on final ACO regulations, but Pioneer ACOs will be granted greater flexibility in certain aspects.
- Designed to work in coordination with other payers (private insurers and Medicaid managed care programs).
Key Features of the Pioneer ACO model:

- Flexibility in length of Participation: Pioneers can participate for up to 5 performance periods.
- Increased risk-reward potential: greater potential gain (also loss) in terms of higher risk, higher reward.
- Flexibility in beneficiary alignment: Pioneers can choose Retrospective or Prospective beneficiary alignment.
- Advanced payment models: payment arrangement goes from FFS in the first 2 years, to population-based payment in the 3rd year.
- Required participation of other purchasers: by the end of the second year, Pioneers must have the majority of total revenue derived from outcomes-based contracts with private health plans, Medicaid, or self-insured employers.
Eligible Provider Groups for the Pioneer ACO Program:

- Networks of Individual Practices of ACO professionals
- Hospitals employing ACO professionals
- Partnerships/JVs between hospitals and ACO professionals
- ACO professionals in Group Practice arrangements
- FQHCs-Federally Qualified Health Centers
The California ACO Ecosystem

- Many cities and states have one or a few provider organizations that already are or may become ACOs.
- But California has 30 years experience with over 200 prepaid physician groups and physician-hospital systems.
- These organizations serve commercially insured patients (mostly HMO), plus Medicare Advantage and Medicaid managed care.
- What has been learned that is relevant to the PPO population and ACO initiatives?
The Distribution of Patients (HMO Enrollees) across Types of Physician Organizations

<table>
<thead>
<tr>
<th>Type</th>
<th>Number of Organizations</th>
<th>Total HMO Enrollees</th>
<th>Commercial HMO Enrollees</th>
<th>Medi-Cal HMO and Healthy Families Enrollees</th>
<th>Medicare HMO Enrollees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Permanente Medical Groups(^1)</td>
<td>2</td>
<td>6,659,879</td>
<td>4,879,844 (73%)</td>
<td>308,236 (5%)</td>
<td>740,173 (11%)</td>
</tr>
<tr>
<td>Integrated Medical Groups(^2)</td>
<td>131</td>
<td>4,425,100</td>
<td>2,682,600 (61%)</td>
<td>1,305,150 (29%)</td>
<td>437,350 (10%)</td>
</tr>
<tr>
<td>IPAs</td>
<td>152</td>
<td>4,849,200</td>
<td>2,629,250 (54%)</td>
<td>1,843,250 (38%)</td>
<td>376,700 (8%)</td>
</tr>
<tr>
<td>Total(^3)</td>
<td>285</td>
<td>15,718,350</td>
<td>10,751,850 (68%)</td>
<td>3,447,150 (22%)</td>
<td>1,519,350 (10%)</td>
</tr>
</tbody>
</table>

There are two Permanente Medical Groups that serve Kaiser enrollees in California, one in the north/central region and one in the southern region. Each of these is formed of multiple large sites. These Kaiser enrollment data are from a 2009 Kaiser Foundation Health Plan Financial Summary Report generated on the website of the Department of Managed Care (http://wpso.dmhc.ca.gov/flash/). The enrollment figures do not add up to total HMO enrollment due to the existence of alternate insurance types.

\(^1\)This includes foundations, medical groups (with or without wraparound components), and community clinics, but does not include Permanente Medical Groups.

\(^2\)The three previous rows do not add up to totals due to differences in data sources.

Data Sources: Cattaneo and Stroud, “\(^7\): Active California Medical Groups by County by Line of Business, for Years 2004 through 2010, Sorted Alphabetically,” May 1, 2010. Provided by W. Barceliona, July 27, 2010, and the Department of Managed Health Care’s Health Plan Financial Summary Report Tool (http://wpso.dmhc.ca.gov/flash/).
ACO in California: Key Dimensions

1. Organizational structure
2. Payment methods
3. Financial solvency regulation
4. Most important: How to balance coordinated care and consumer choice of provider and treatment?
1. Organizational Structure and Size

- Both integrated medical groups and IPAs can be successful, and neither is displacing the other
- Ownership by a hospital system can be successful but many medical groups remain independent
- There is a full range of organizational sizes, with only a modest trend towards consolidation
- Narrow network products are selling successfully in some markets, but rely on having provider organizations that focus on market share rather than pricing leverage
## Patients Who Receive Care from HMO ACOs

<table>
<thead>
<tr>
<th>Insurance Type</th>
<th>All Types (Total Enrollees)</th>
<th>Commercial</th>
<th>Medi-Cal / Healthy Families</th>
<th>Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACO HMO Enrollment in CA</td>
<td>15,943,850</td>
<td>11,285,950 (71%)</td>
<td>3,164,000 (20%)</td>
<td>1,493,900 (9%)</td>
</tr>
<tr>
<td>Entire Insured Population in CA</td>
<td>29,691,000</td>
<td>20,110,800 (68%)</td>
<td>6,036,300 (20%)</td>
<td>3,308,800 (11%)</td>
</tr>
<tr>
<td>ACO HMO Enrollment as a Percent of Total Enrollment</td>
<td>54%</td>
<td>56%</td>
<td>52%</td>
<td>45%</td>
</tr>
</tbody>
</table>

Note: The total insured population is larger than the sum of the total commercial, Medi-Cal and Medicare enrollees due to the presence of other types of insurance (e.g. TRICARE).

Organizational Structure: Lessons

- What is important is the set of capabilities rather than structure or scale
  - Financial management and discipline
  - Care management and quality reporting
- Can a network with a small number of high-performing medical groups and IPAs serve as the basis for a PPO product, where enrollees traditionally have favored choice?
  - Will efficiency gains be sufficient to compensate for less choice?
  - There will continue to be broad choice outside the ACO albeit at higher cost sharing
2. Payment Methods

- Major differentiator of medical groups in CA v. US is important role of capitation
  - This drives efficiency but also transfers risk
  - Turbulence of medical group finances
- But the scope of capitation has narrowed
  - Retreat from hospital and pharmacy capitation
  - This reduces risk but also incentive to manage the full continuum of care
- Hybrid payment methods are emerging
Current ACO initiatives build on PPO and supplement it with incentives for coordination:

1. Fee schedule (paid to physicians)
2. Care management PMPM costs (paid to ACO)
3. Shared savings potential (paid to ACO)

Will move from shared savings (upside only) to partial capitation (up/downside risk) over time.

Goal is global capitation with safeguards?

- This would require DMHC approval
- Limited Knox Keene licenses?
ACOs required to report performance on clinical, patient satisfaction, and efficiency metrics

- Where possible, these metrics are based on P4P and other already-collected data
- Baseline is the ACO’s performance over two years
- Attainment/improvement on quality/satisfaction is required for ACO to receive any shared savings
- Efficiency metrics are required to ensure that savings in overall PMPM expenditures are real, not due to chance or measurement only:
  - Generic substitution, ASC use, reduction in LOS and ED use, etc.
3. Financial Solvency Regulation

- Capitation motivates efficiency but also increases financial risk for medical groups
  - Business risk and insurance risk
- Major turbulence 1999-2003 when groups believed in economies of scale, accepted low payment rates and expanded very quickly via mergers
  - 150 groups went bankrupt, affecting 4 million patients
- Since 2002, there has been major decline in turbulence
- Stronger regulation of financial solvency
  - Required disclosure of selected financial ratios
  - Required financial reserves
Large physician and hospital organizations that accept capitation payment must develop financial discipline and reserves.

California has extended some forms of insurance regulation to apply to medical groups, and financial turbulence has declined dramatically.

Financial solvency regulation will be important as ACOs extend into the PPO population.

The key is finding the right balance of appropriate regulation that does not stifle the creation of ACOs, but which weeds out the weaker ones.

Financial Solvency Regulation: Lessons
Medical groups emphasize coordination of care by channeling referrals within the group, but many consumers value broad choice of physicians at the time of care and do not accept ‘gate-keeping’

Medical groups offer many disease management (DM) programs for chronically ill populations and case management (CM) programs for those with complex conditions, but some patients do not value these

If the medical group model is to survive, it must be able to serve PPO enrollees with more choice of provider and a lighter version of DM and CM
Care Management in the PPO Environment?

- The promise of ACO is that care management (CM) improves quality and moderates costs
  - Disease management for chronic conditions
  - Complex case management
  - LOS management: hospitalists, transitions of care (discharge planning etc.)
  - Pharmacy management & generic substitution
  - Preventive screenings and wellness
Delegation of CM is difficult in PPO

- Hard to the PPO to delegate CM for enrollees who are affiliated with ACO but not for other enrollees in PPO (who are not in an ACO)
  - Variation in breadth of CM programs operated by the PPO for different employers
  - Variation in breadth of CM programs across ACOs
  - Large employers often carve DM/CM out to specialty companies

- Some PPO customers dislike care management; that’s why they are in the PPO

- Data exchange between PPO and ACO is imperative but difficult
Leading plans and provider organizations are developing PPO products where the physician network is based on medical groups and IPAs rather than individual physician practices.

Challenges and opportunities:
- Linking patients to providers
- Information and data exchange
- Payment methods
- Care management

How large is the market opportunity?