OPTUM

Lessons Learned from the Pioneer ACOs: Monarch HealthCare ACO, Performance Year 1

Agenda

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- Why Did Monarch Choose to Participate in the Pioneer Program?
- Performance Year 1 Results
- Key Success Drivers
- Lessons Learned
- Performance Year 3 Strategy
- The Future of the ACO Model

About Monarch HealthCare

- Founded in January 1994 with the consolidation of three IPAs
- Contracts with nearly every major health plan with a California presence
- Largest Independent Practice Association (IPA) in Orange County, California
- HMO Network
  - ~650 PCPs, ~1,600 specialists, 19 contracted hospitals
  - 187,000 HMO patients (including ~38,000 Medicare Advantage patients)
- Pioneer ACO – 1 of 32 selected for participation
  - ~300 PCPs, ~50 specialists
  - 21,856 ACO beneficiaries
- Brookings Dartmouth ACO – 1 of 5 selected for participation
- Commercial ACOs – Actively discussing ACO arrangements w/ commercial payers

Why Did Monarch Choose to Participate in the Pioneer Program?

- Nationally, the medical cost trajectory is unsustainable
- The greatest impact can be achieved by coordinating care for the most vulnerable and expensive population - chronically ill seniors in the Medicare FFS system
- Monarch was accepted into program due to expertise in improving clinical outcomes through coordinated care and bearing financial risk for large senior populations
- Significant synergy with existing Medicare Advantage business; IT and clinical infrastructure already in place
- The Pioneer Program's "Triple Aim" objective is perfectly aligned with Monarch's long-standing mission, values, and core competencies
  - Improve the quality of care.
  - Improve the health of populations.
  - Reduce the cost of care.

Performance Year 1 Results

Quality Performance

- Top performer in several “Patient/Care Giver Experience” metrics
  - Monarch scored highest in “Physician communication with the patient” and “Patient overall satisfaction with their physician”
- Top performer in several “Care Coordination/Patient Safety” metrics
  - Monarch scored highest in prevention of admissions for ambulatory sensitive conditions

Medical Cost Reduction

- 2nd highest performer in the Pioneer program in PY1
- Monarch reduced medical cost ***-5.4%*** in 2012 from its baseline, while national medical cost grew +1.1% for a comparable population
- This favorable expense trend was driven primarily by reductions in hospital admissions, and SNF utilization and unit costs

Key Success Drivers

1. **Network Selection**
   - Invited a narrow list of top performing physicians (mostly PCPs) to participate in ACO (vs. shotgun approach)
   - 70% of aligned network on common EHR platform
2. **Performance-Based Incentives**
   - Incentives for PCPs to perform an Annual Wellness Visit, complete a Health Risk Assessment, and perform key health screenings for each attributed patient
     - Resulted in greater than 95% physician participation and collection of HRAs for 38% of patients
3. **Targeted care management**
   - Identification of high risk patients using Optum risk stratification tools and Actuarial Services
   - Provide access to Care Navigators, dedicated case managers, home visiting physicians, and personalized pharmacy care

Key Success Drivers

4. Physician Tools

- Practice Connect ®
  - Proprietary point-of-care web interface which displays a summary of a patient's 12-month medical history
  - Highlights significant clinical events such as recent hospitalizations or ER visits
  - Also identifies patient diagnoses, recent lab results, list of other attending physicians, and required preventive screenings
- Annual Senior Health Assessment (ASHA)
  - Addresses comprehensive list of patient screenings required for comprehensive care of a senior and addresses majority of ACO quality metrics
  - Document is mostly completed by patient in the form of a pre-exam survey and reviewed by physician with patient during Annual Wellness Visit
  - Becomes part of medical record once complete

Lessons Learned

- Patient engagement remains challenging
  - Patients and physicians often don’t agree with how they are aligned
  - 70-80% of ACO patient office visits are with specialists
  - Patients suspicious of ACO services and don’t understand the value of care coordination
  - Patients are most likely to engage (1) if their physician endorses the ACO and (2) they’ve recently been discharged from the hospital after an acute event
- Patient resistance is reportedly driven by:
  - Fear of change in benefits and increased out of pocket costs
  - Fear of losing their freedom of choice
  - Fear of being taken advantage of or unanticipated enrollment in Medicare Advantage program

Lessons Learned

- Requires engaged physicians and office staff
  - Physician understanding driven by frequent communication and performance reporting
  - Office staff must also be incentivized to identify ACO patients and support performance goals
- Care management infrastructure and managed care expertise are significant advantage
- Requires multi-disciplinary support

Performance Year 3 Strategy

- Improve specialist engagement
  - Acknowledge specialists as principal care givers and treat them like PCP for chronically ill
  - Identify high performing mini-networks of physicians and experiment with performance-based incentives
    - Shared risk for “attributed” poly-chronic patients
    - Episodic / bundled payments
- Promotion of price and quality transparency
  - Publication of specialist clinical outcomes and relative episodic performance to the physician network and to patients
  - Publication of comparative hospital costs and quality performance across common procedures to the physician network and to patients
- Invest in partnerships with hospitals, SNFs, and ancillary vendors
  - Offer incentives for lowering readmission rates, contributing to quality performance

The Future of the ACO Model

- Monarch has committed to remain in the program for PY2
- We applaud CMMI's efforts to give ACOs additional tools
  - Eg. Waiver to the "3 Day Inpatient Stay Rule"
- We support CMMI's interest in evolving ACO regulations, to allow us to more effectively improve quality and reduce cost, particularly changes that allow us to:
  - Test new methods of payment, including true population-based payment
  - Test patients incentives for choosing high quality, low cost services
  - Engage patients more effectively through "voluntary attribution"
  - Limit ACO risk for attributed patients living outside ACO's service area
- Monarch expects to see significant growth in programs that reward quality improvement and care coordination for the Medicare FFS population