



The Model Matters: as Providers Assume Risk, the Value of Care Increases

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Health Affairs September 2018 Issue: Is this the Last Word on Integrated Care?



- Hospital price increases driving system costs
- Negative impact of hospital/hospital horizontal integration on competitiveness
- Negative impact of physician/hospital vertical integration on competitiveness- termed a national “megatrend”
- Failure of “ACOs” to improve value

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About the Integrated Healthcare Association (IHA)

Founded in 1994 as a 501(c)6 NFP and guided by the state's leading healthcare organizations, IHA advances integrated care



IHA's Align. Measure. Perform. (AMP) & Atlas



AMP

- **Measures:** 50 highly aligned measures of clinical quality, utilization, total cost of care
- **Who's Included:** Commercial HMO, commercial ACO, Medicare Advantage, Managed Medicare
- **What's Viewable:** physician organization level performance

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- **Measures:** Over two dozen standardized measures of clinical quality, utilization, total cost of care
- **Who's Included:** 29 million Californians inclusive of commercial HMO, PPO, Medicare FFS, Medicare Advantage and Medi-Cal
- **What's Viewable:** geographic and product line performance information

Built on a single data platform with standardization throughout

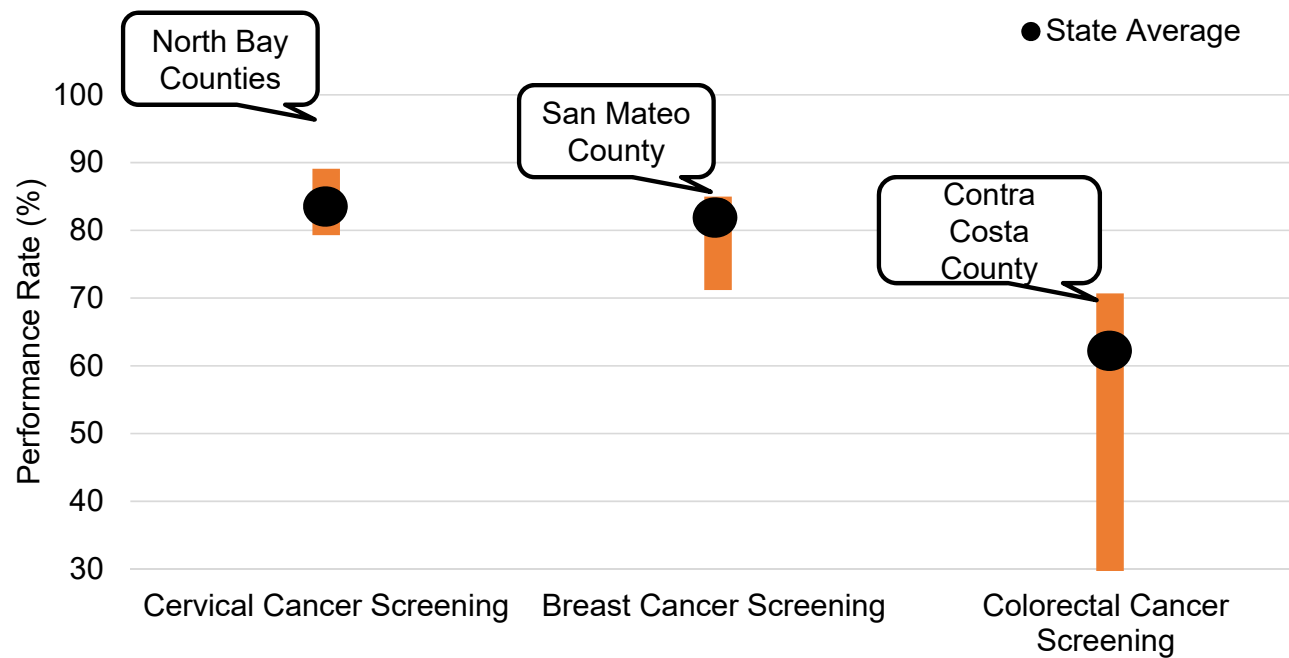
Cost & Quality Performance Variation - Commercial Enrollees



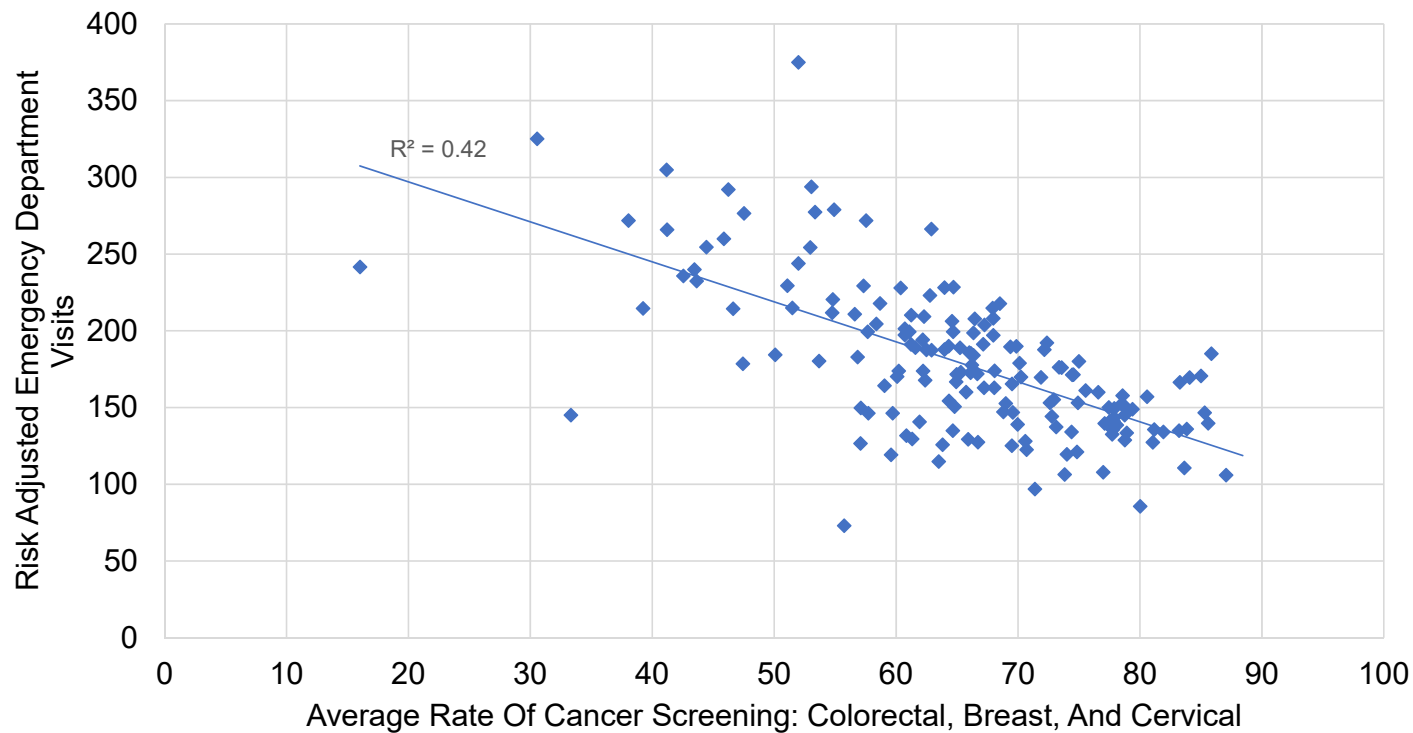
Key Commercial Takeaways

- There is wide variation in cost and quality in CA that is persistent over time regardless of health plan product or provider delivery model
- Health plan products that limit patient cost sharing and use integrated networks show superior cost and quality
- Financial risk sharing (capitation) between plans and providers drives higher quality and lower costs—the more capitation, the better the performance
- Accountable Care Organizations (“ACOs”) have variable cost and quality performance but are superior to non-integrated care networks

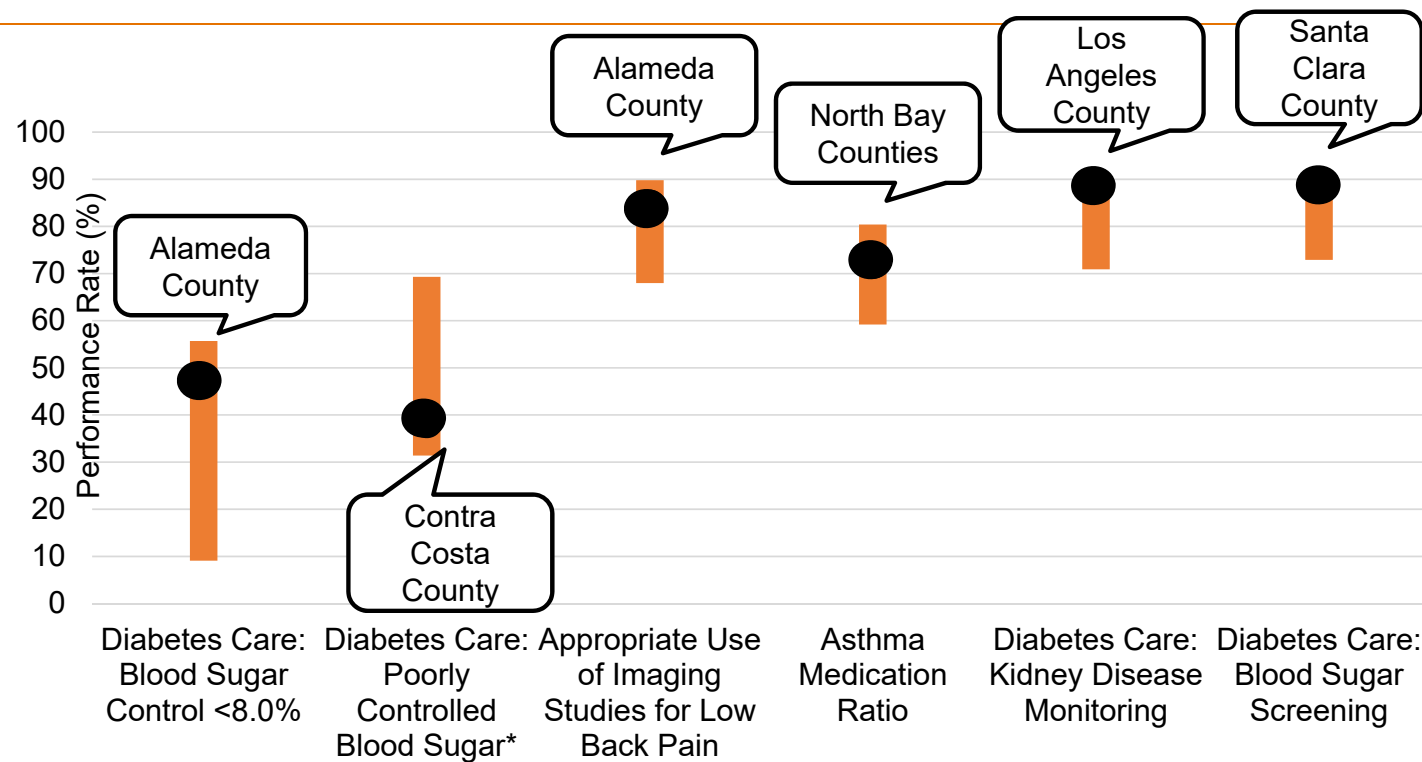
Disease Prevention - Wide Variation



Prevention and Access - Close Cousins



Chronic Care Management - Wide Variation



● State Average

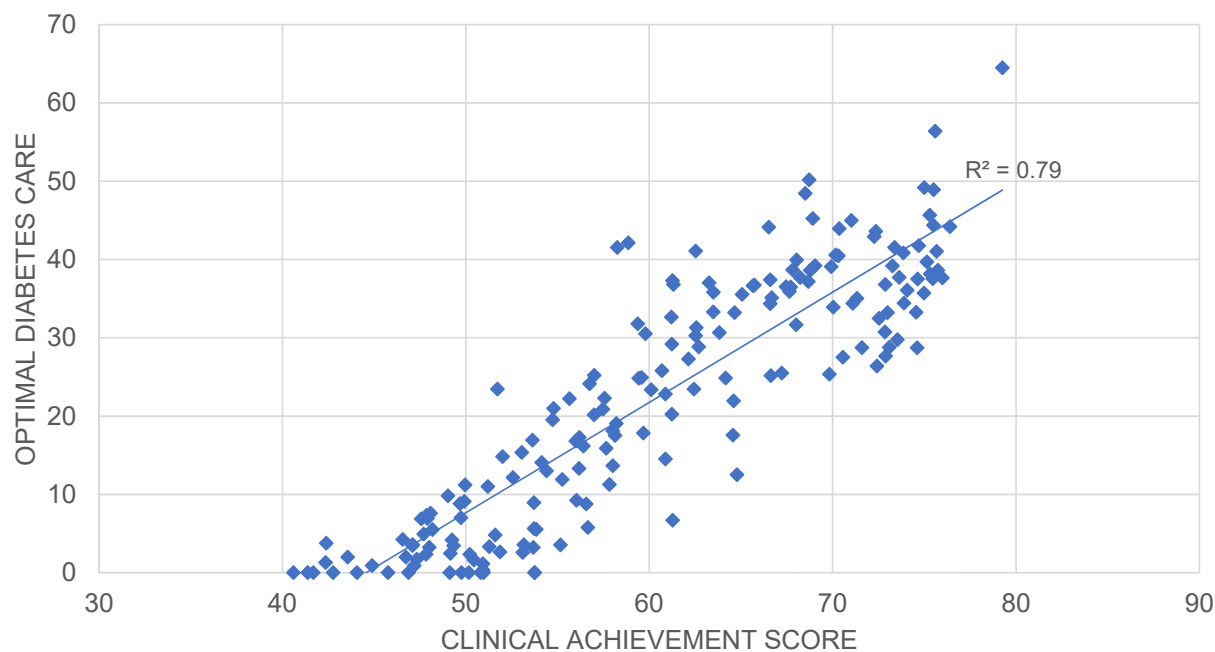
* Lower is Better

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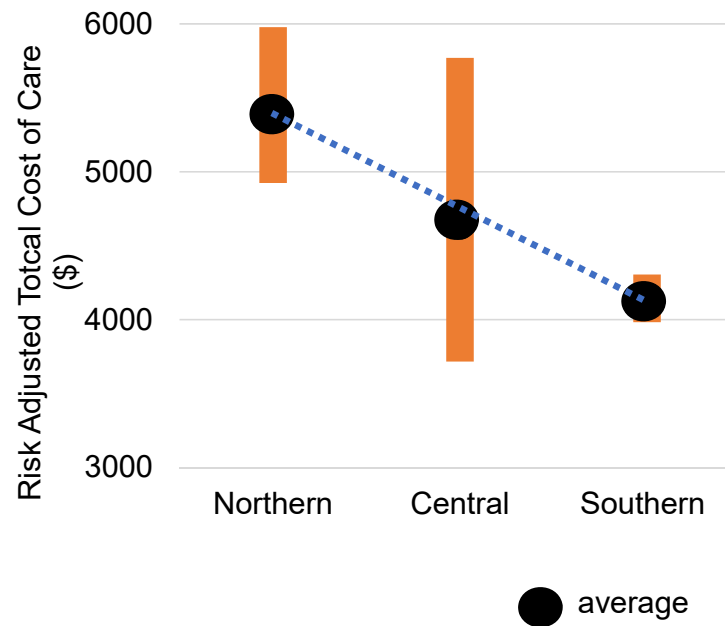
What Can a Few Measures Really Tell Us?

Actually quite a lot - diabetes example

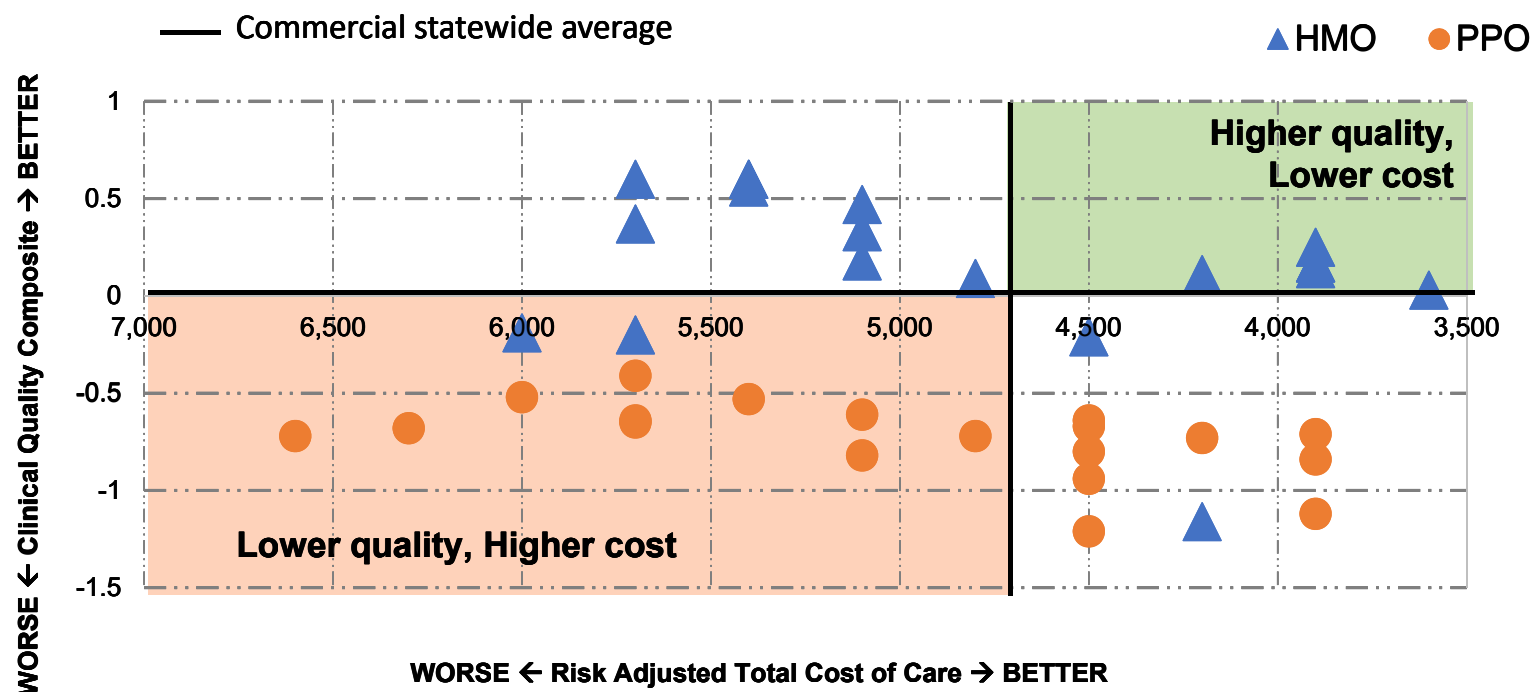


Note: Clinical Achievement Score is a composite of 25 clinical measures

Wide Variation in Cost within and between CA Regions



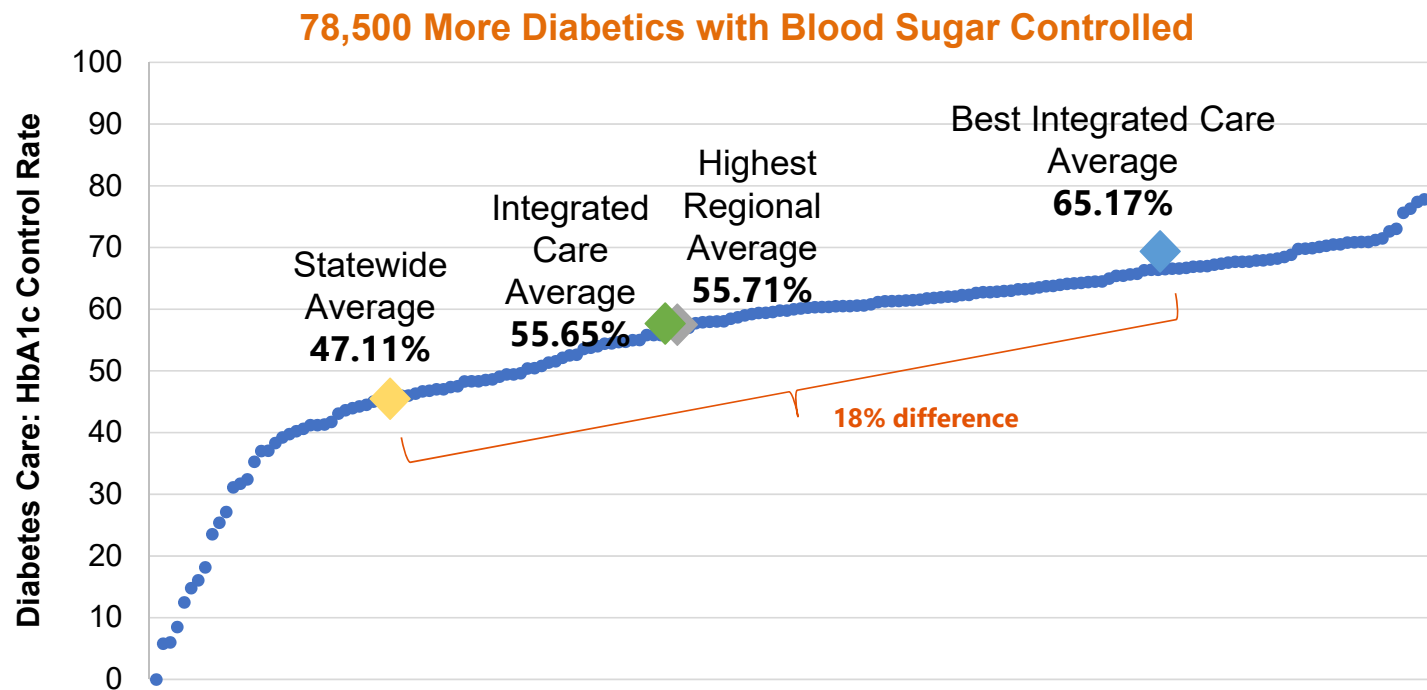
Commercial HMOs can Provide Higher Value



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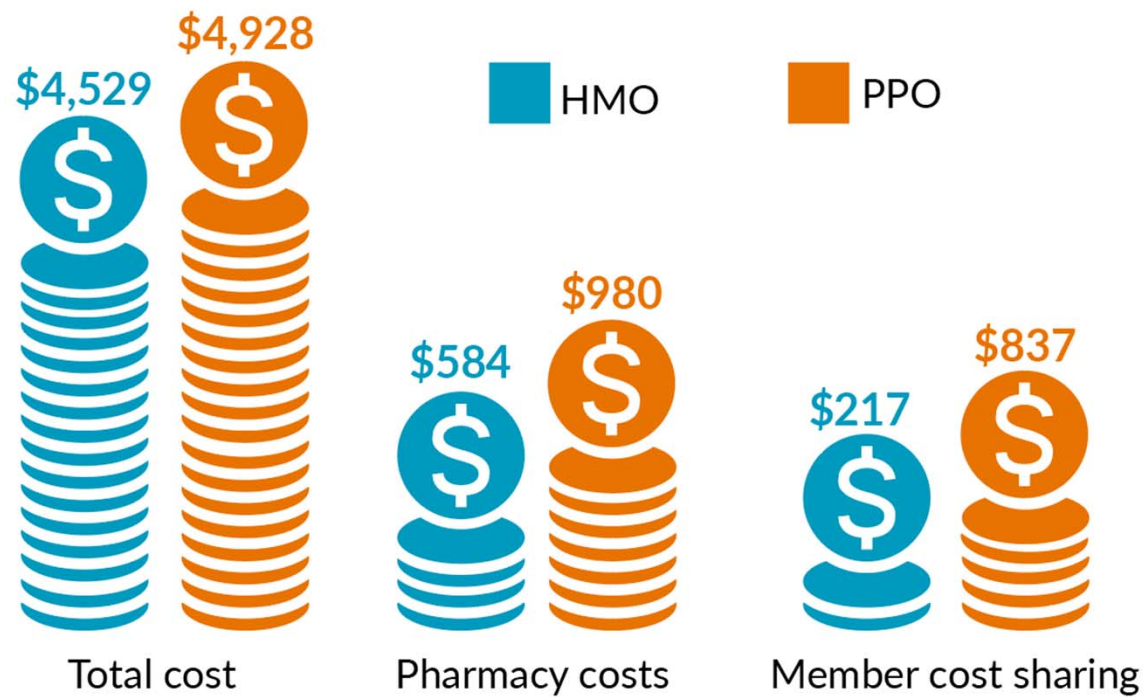
The Delivery Model Matters - Integrated Care Outperforms (typically HMO)



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Commercial Cost Breakdowns



Another View - Financial Risk Sharing Impact on Costs & Quality

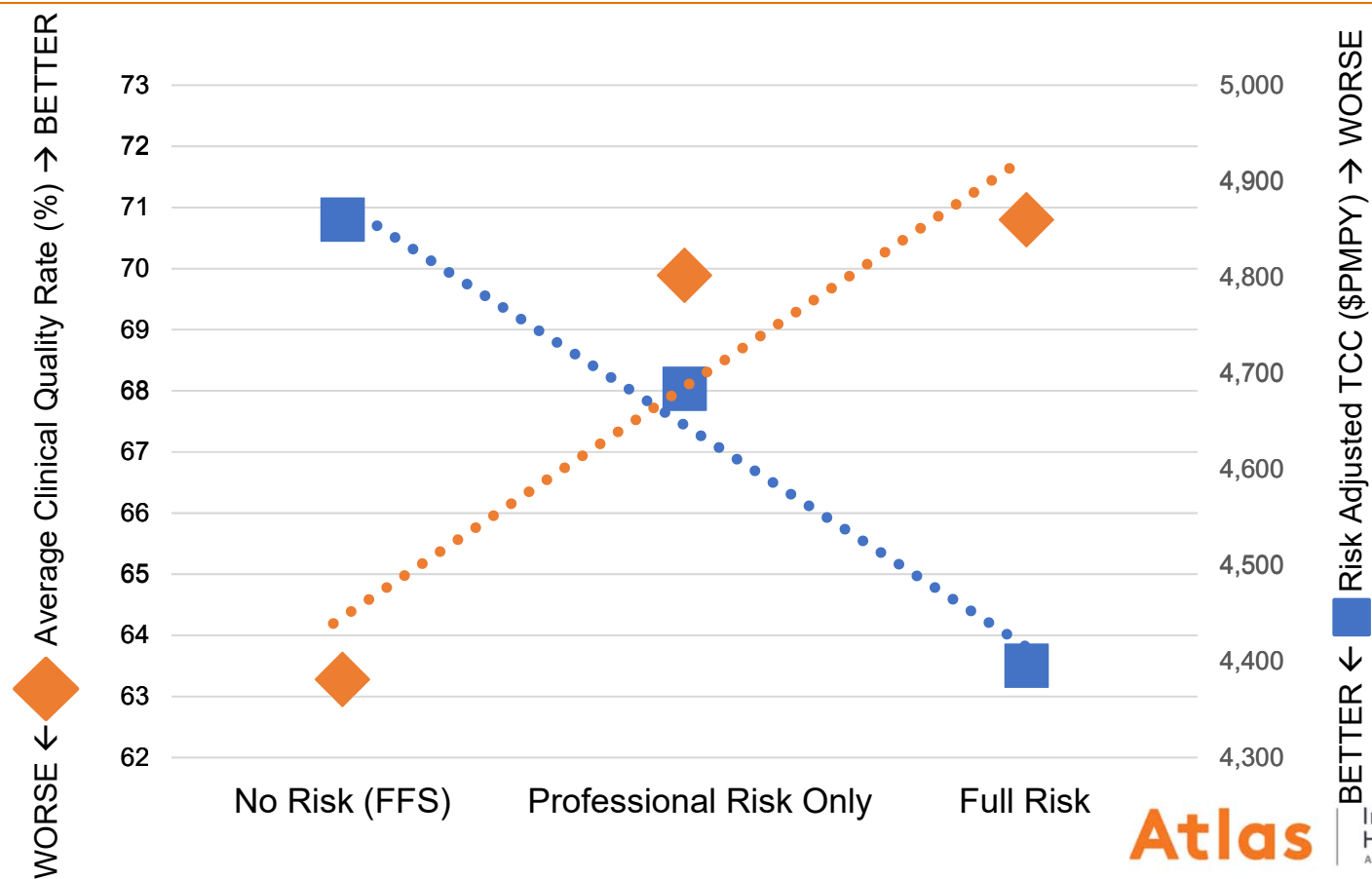
Definition of Risk Types used in IHA Analysis

- **No Risk (FFS)** – fee for service (FFS), no capitation
- **Professional Risk Only** – no facility capitation
- **Full Risk (two types)**
 - **Global Risk*** – single capitation contract with PO for both professional and facility. Eligible to apply for a DMHC Restricted Knox Keene (plan) license
 - **Dual Risk*** – two separate capitation contracts for professional services (with PO) and facility services (with hospital or PO)

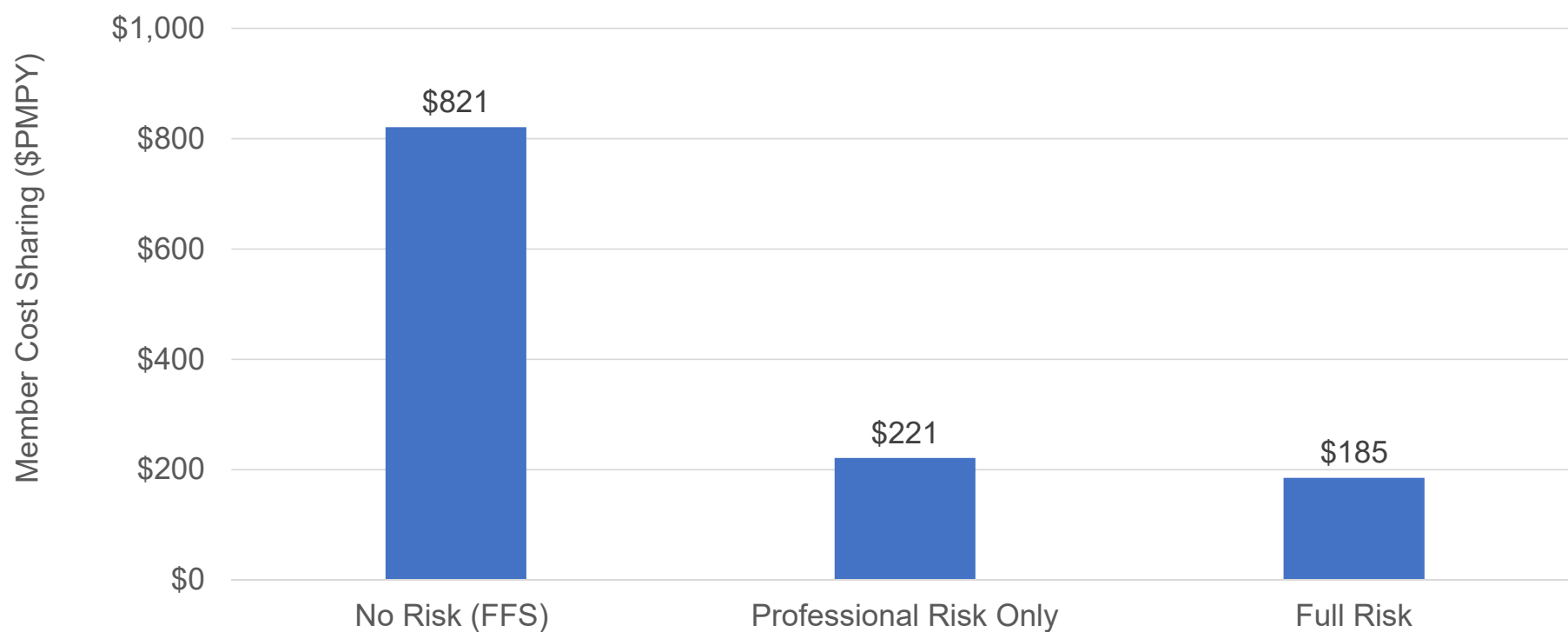
*designation left to plans as part of data submission request

NOTE: CA DMHC definition of “Risk Bearing Organization (RBO)” is a physician led organization with any level of financial risk sharing that pays claims

Another View - Degree of Risk Sharing Impact on Cost & Quality



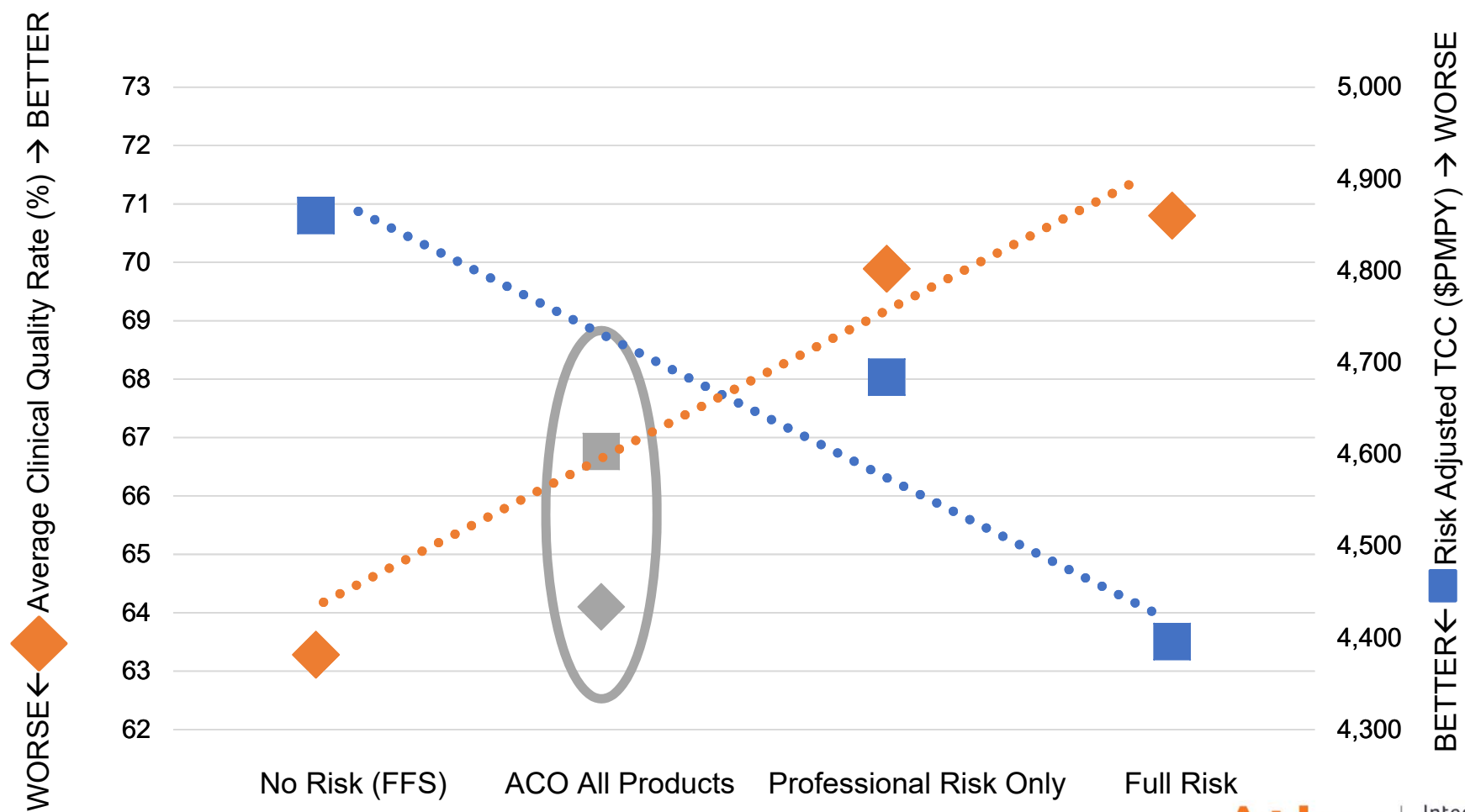
Member Cost Sharing Lowest for those in Provider Groups Taking Financial Risk



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Do “ACOs” Improve Value?



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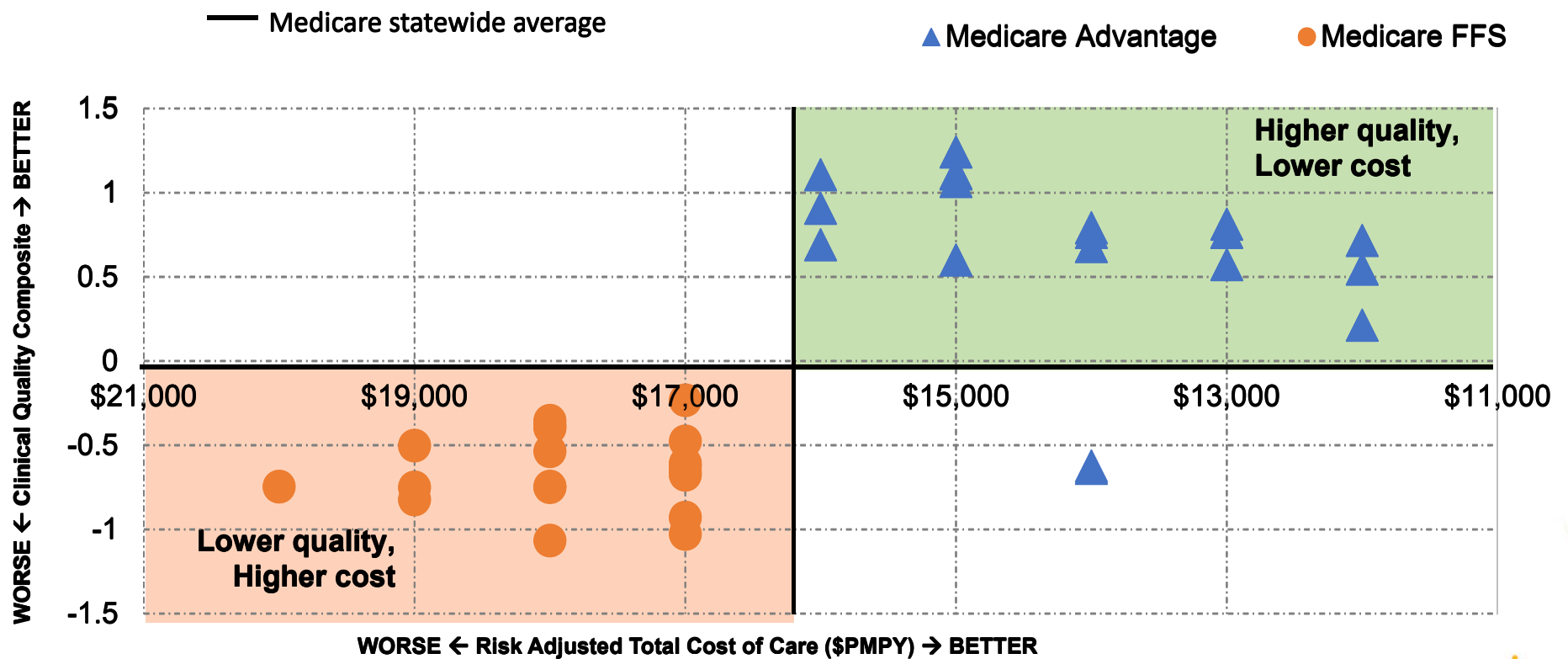
Cost & Quality Performance Variation - Medicare Enrollees



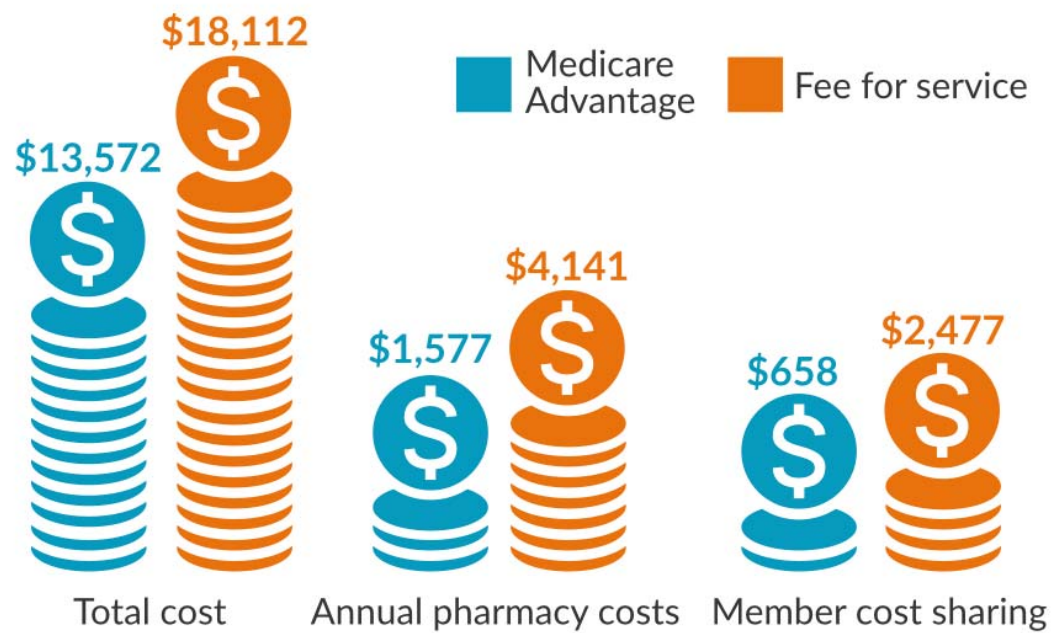
Key Medicare Takeaways

- Consistent and even more pronounced than commercially insured, Medicare Advantage (MA) programs provide much higher quality, lower total cost of care and lower out of pocket expense than traditional Medicare
- In addition, the integrated groups/IPAs that perform well in MA, also perform well in other lines of business
- Wide geographic variation still is evident

Dramatic Value Advantage for Medicare Advantage



Medicare Cost Breakdown



Cost & Quality Performance Variation - Medi-Cal Enrollees

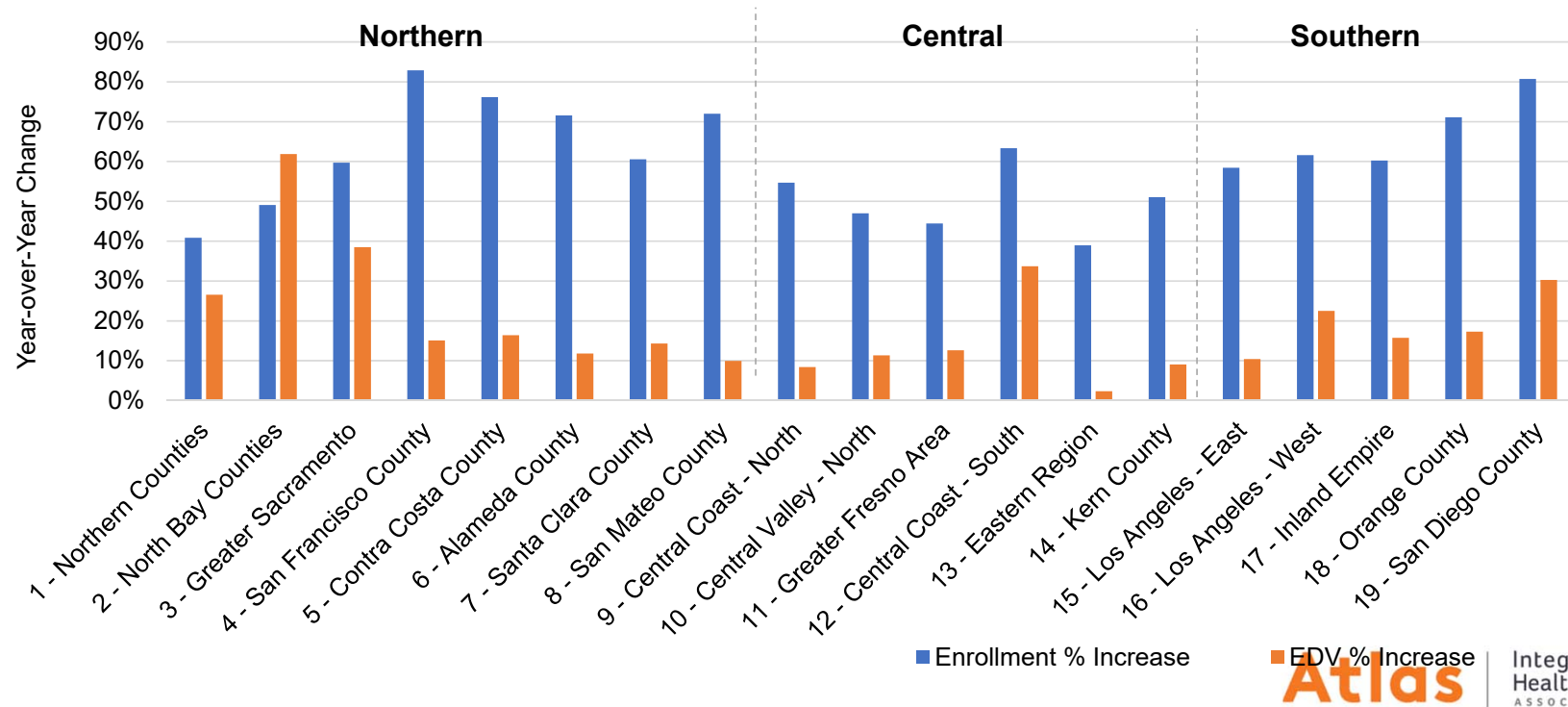


Medi-Cal Key Takeaways

- Quality performance is more consistent across the state for Medi-Cal populations
- The overall rates for preventive health declined after Medi-Cal expansion
- ED use increased significantly after expansion, however the increase was not strictly related to the areas of highest enrollment growth
- Different managed Medi-Cal models (GMC, COHS, Two plan model) show different performance
- The lack of member level data for Medi-Cal significantly limits the ability to generate information both within the Medi-Cal sector and across sectors or geographies

Regions with Highest Enrollment Increase do not always have Highest ED Visit Increase

Even though Southern CA contains bulk of Medi-Cal enrollment and largest enrollment increase, Southern CA has better controlled ED Visits than other regions



What Would High Value Care in CA Deliver?

If care for all commercially insured Californians were provided at the same quality as the top-performing region:



205,000 more people would have been screened for colorectal cancer



30,500 more women would have been screened for breast cancer

If care were provided at the same cost as the top-performing high-quality, low-cost region:



overall cost of care would decrease by an estimated \$6.2 billion annually, a >10% decrease

Atlas 3 will be released in early April, then annually going forward

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The Data, but maybe not Time, is Integrated Care's Friend

- Need to Discern Relationship between:



- Capitation-financial
- Clinical Integration
- Consolidation

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Questions?

