How ACOs Can Position to Compete in a Direct Contracting Environment

Theresa Hush, CEO and Co-Founder

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Photo by Aaron Burden

There was a plan to encourage provider engagement in costs and quality of patient care, through the development of Accountable Care Organizations.

Now that they're not the only plan, how do ACOs create their future?

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Topics for Today

- What Medicare Value-Based payment models – and shifting priorities -- say about the future of Medicare
- What is the real competition to ACOs?
- Does Medicare's Direct Contracting effort hurt or help ACOs?
- What arrangements are open to ACOs in Direct Contracting?
- What is the best game plan for ACOs to benefit through Direct Contracting?
- What do ACOs pursuing a DCE path need to do to be competitive - and relevant?

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We Won’t Address:

- DCE cost benchmarking and capitation formula
- Risk adjustment formulas
- Infrastructure requirements for DCEs
- How to hold on until / if all this is behind us

Informed Perspective

- Walked in boots of public policy development, government health care (Medicaid and largest employee benefits group in IL) and scarce resources
- Trudged on battlefield of implementing strategies and change inside academically-based health system, including managed care with capitated risk
- Experienced the stratosphere of major health plan contracting and product development, including local Medicare Advantage products (UnitedHealthcare)
- With Co-Founder Tom Dent MD, founded Roji Health Intelligence to help health care achieve better results for patients at an affordable cost.

Since 2002, Roji Health Intelligence has helped health systems and physicians measure and improve patient quality and lower costs through technology, services and strategic consultations.

I’ve seen things you people wouldn’t believe…

Blade Runner

What Medicare Value-Based payment models say about the future of Medicare

Medicare Value-Based Landscape Is Busy

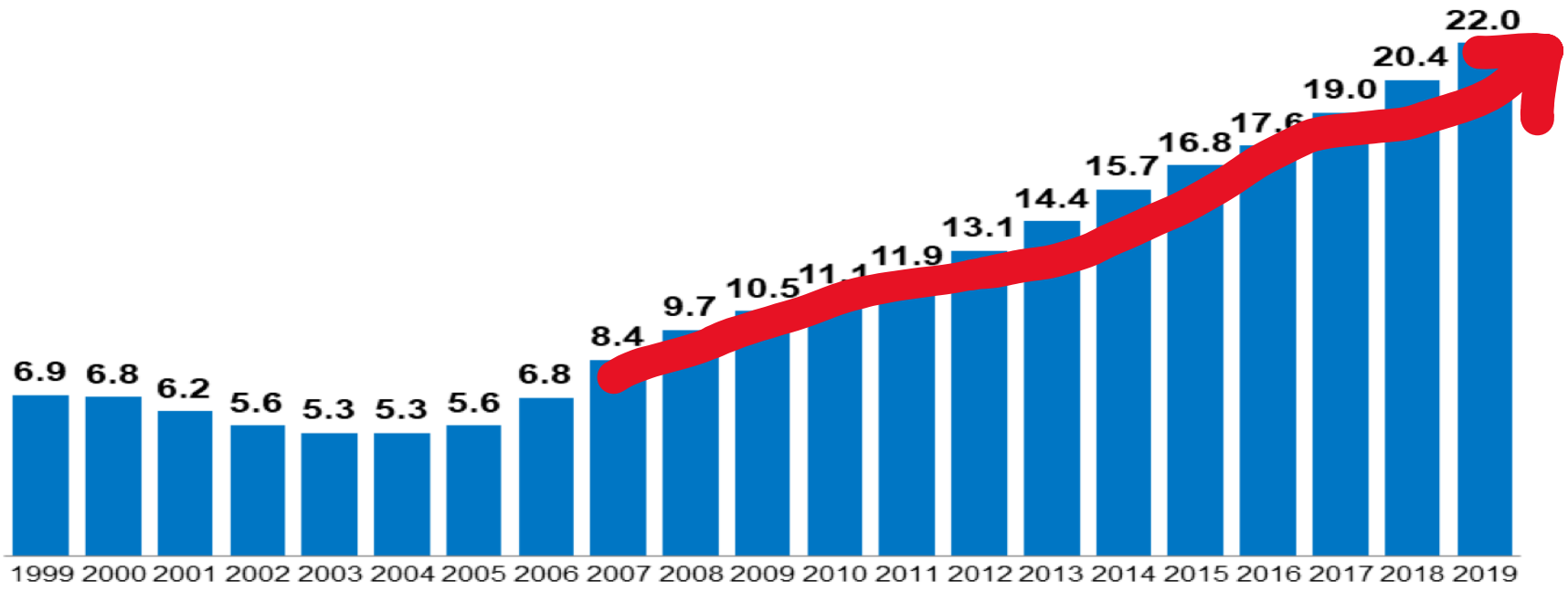
- Medicare Advantage
- MSSP ACOs – Tracks with Downside Risk
- Next Generation ACOs
- Direct Contracting
- Primary Care First
- CPC+ Groups
- Specialty Care Models and Bundled Payments

Photo by Cristian Gecu

MA Plans Have Seen the Largest Growth

Figure 1

Total Medicare Advantage Enrollment, 1999-2019
(in millions)



NOTE: Includes cost plans as well as Medicare Advantage plans. About 64 million people are enrolled in Medicare in 2019.
SOURCE: Kaiser Family Foundation analysis of CMS Medicare Advantage Enrollment Files, 2008-2019, and MPR, 1999-2007; enrollment numbers from March of the respective year, with the exception of 2006, which is from April.

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Why is MA Growth Significant?

- It is capitated for Medicare, and MA capitation of participating providers is growing
- Patients actively choose to be in an MA plan
- CMS publicly praises Medicare Advantage, and gives special benefits
- CMS has referenced MA as an alternative to provider-based models
- Can MA be Medicare's alternative plan for capping / privatizing Medicare?

- Bottom line: 1. CMS believes MA is a cost-effective model 2. As MA moves risk downstream to physicians, it poses a choice for providers: Risk through MA or Risk through its own DCE / ACO.

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CMS Has Challenged ACOs to Evolve

- Pushed downside risk in Pathways to Success
- Challenged model effectiveness – MedPac
- Questions / offers alternative view of Next Generation ACO results
- Developed alternative models for providers unwilling to participate in ACOs
- So far, has held ground on payment models, Next Generation term
- Frequently and publicly targets FFS payment model

- Bottom line: CMS support for ACOs is contingent on its success in capping costs through risk, and change in payment structure

Direct Contracting: Originated as a “Primary Care Model,” but also became way to achieve CMS’ objectives for ACOs

Multiple Models Force Change

- Direct contracting forces ACOs to compete for patients
  - With their own groups who may be more competitive or pro-risk
  - With other ACOs who are DCEs and can lower cost

- Change in payment model built on a voluntary adoption of capitation: forces providers to scramble and consider future.

Does Direct Contracting hurt or help ACOs?

Photo by Ashley Knedler

Direct Contracting Changes Goals and Rules of Game

- Patient volume = competitive leverage
- Long-term total patient care costs, vs short-term, is what matters – The Financial Objectives will completely change from ACOs now
- Younger & healthier patients become essential to financial success – means organization must reach out to health plans & employers
- Containment of primary care leakage is essential
- Referrals must be selective, and control costs generated by preferred providers

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Choose Not to be DCE?
ACOs May Lose to Competitive Groups

- MSSP ACOs with no downside risk: Sizeable, progressive participating groups may defect from ACO to compete.
- Small ACOs challenged by resources: inability to brand/keep patients.
- Large-hospital-based ACOs: eventual loss of market share and gravitation of patients to MA.

Photo by Ashley Knedler

Choose Not to be DCE?
ACOs May Also Lose Primary Care Physicians

- Primary care network is already challenged:
  - Fewer physician owners
  - Practice size is larger
  - More hospitals as owner
  - Internists are increasingly in large multi-specialty groups

Source: AMA 2018 Physician Practice Benchmark Survey

Photo by Ashley Knedler

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Choose YES to ACO-DCE?
Partial Risk Will Limit Competitiveness

- Resources under partial risk will be limited
- Without negotiating downstream care, partial risk DCEs have reduced opportunity to be relevant to specialists
- Partial Risk DCEs will remain administrative and unbranded – poor growth prospects
- Infrastructure and people costs will be a factor in both PR and GR

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Only Global Risk Provides Opportunity for Competitive Positioning

IF the ACO has the correct alignment with its participating providers -- and the data / infrastructure needed to create long-term value for patients

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What Arrangements are Open to ACOs in Direct Contracting?

Choice of Role:

- ACO can be DCE
- ACO can be MSO to DCEs
- Groups in ACO can be DCEs

Choice of DCE Risk Level:

- Partial Risk
- Global Risk

How ACOs Decisions Will Determine Market Positioning

- Growth
  - Risk contracts with commercial plans
  - Employer contracting feasibility
- Branding, Patient Marketing & Retention
- Resources
- Whether focus is administrative or health care

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What do ACOs pursuing a DCE path need to do to be competitive - and relevant?

Photo by NASA

5 Issues ACOs Must Take On to Compete

- Consumer loyalty and customer service
- Medical decision-making
- Data and technology
- Changing physician roles
- Referral arrangements

Photo by NASA

Consumers and Patients

- Providers refer to “patients” -- but most patients now consider themselves “consumers”
- Consumerism in health care is rising with their share of costs
- Studies show increasing distrust of providers who control their data, cost information, and choices
- Health care inequities have contributed to distrust among women
- To grow and expect engagement, providers will need to change their mind-set about patients / consumers.

Photo by NASA

Consumer Loyalty and Customer Service

- There is no engaging a patient who is already annoyed
- Physicians need time and support
- Transparency of cost is essential
- Patients want to decide based on evidence as well as cost

Photo by NASA

Data and Technology

- Global Risk precludes use of spreadsheet technology and simple tools
- Artificial Intelligence will become more important to configure best path for patients defined by their risks
- Many sources of data will be necessary – not only claims

Photo by NASA

Data to Drive DCE Interventions

• *Patients:*	• *Referrals:*
• Risk adjustment data, SDOH • Patient goals and prefs • Claims data • Practice clinical data	• Cost profiles • Quality /outcome data • Volume • Patient Costs PMPM/Y by Episode
Costs:	***Quality / Outcomes:***
• PMPM / PMPY • Predicted to Actual • Episodic by chronic condition • Variances by patients / physicians	• Outcomes compared to patient goal • Outcome improvement over time • Variances by patients / physicians • Patient feedback

Photo by NASA

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Medical Decision-Making

- Strongest cost interventions: Changes in medical decisions
  - Patient decisions not to undergo treatments of no value, based on research evidence.
  - Physician time for reviewing evidence and patient goals to guide process.
  - Organizational support for creating decision support materials / system.
- Transparency of cost is essential
- Help for physicians in changing role

Photo by NASA

Changing Physician Roles – Physicians Not on Positive Path for DCE Growth

- 22% Limit or refuse Medicare patients
- 46% plan to change career paths
- 80% say that they are at full capacity – or overextended
- 17% plan to retire
- 22% will reduce hours in next 1-3 years

Source: The Physician's Foundation, 2018 Survey of America's Physicians

Photo by NASA

Changing Physician Roles – 5 things "too busy" Physicians Say They Want

1. Understanding of risk and choice in activities
2. Extra resources to support work
3. More patient-facing time
4. Data/ information for medical decision-making
5. Seeing patient cost and outcomes

Photo by NASA

Reality Check on HCE-to-Physician Info Sharing

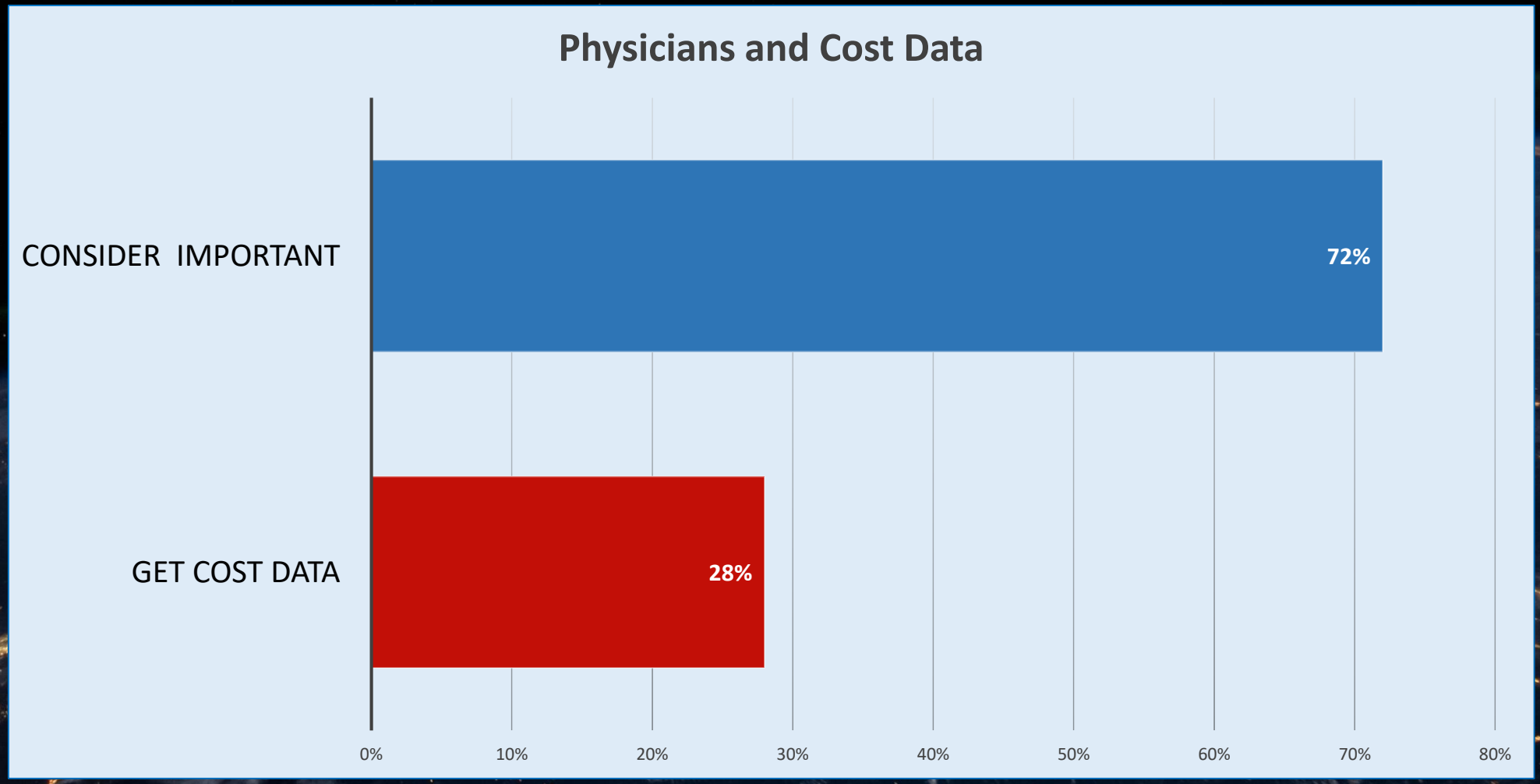

Photo by NASA

Source: Deloitte 2018 Survey of US Physicians

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Referral Arrangements

- DCEs with Global Capitation must better select downstream care
- Negotiation – dictated by leverage of DCE & preferred providers
- Episodic cost data & volume will be essential to selections
- Primary care physicians – should collect patient feedback on outcomes, provide coordination / communication score

Photo by NASA

It is unlikely that Medicare will change course on Risk, regardless of administration.
Why?

- The budget situation is becoming desperate.
- U.S. health care costs have become a focus for everyone -- consumers, providers, business and politicians.
- FFS has been a target for a long time and incentivizes volume
- Provider consolidation and better data has made it possible.

ACOs and Other Groups can Succeed as DCEs Under Risk.

It requires change that can benefit the organization, providers, and patients.

We are here to help.

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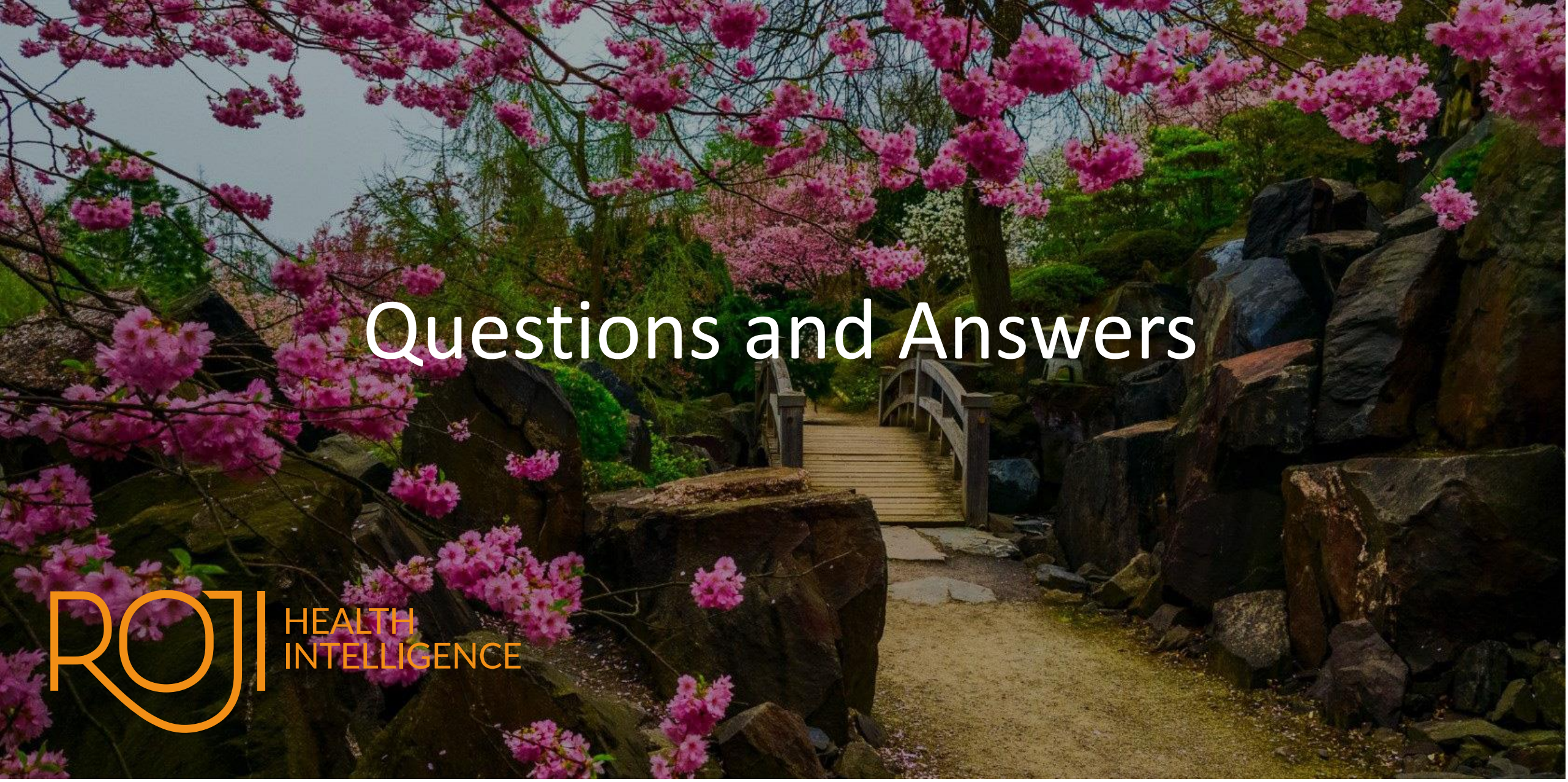

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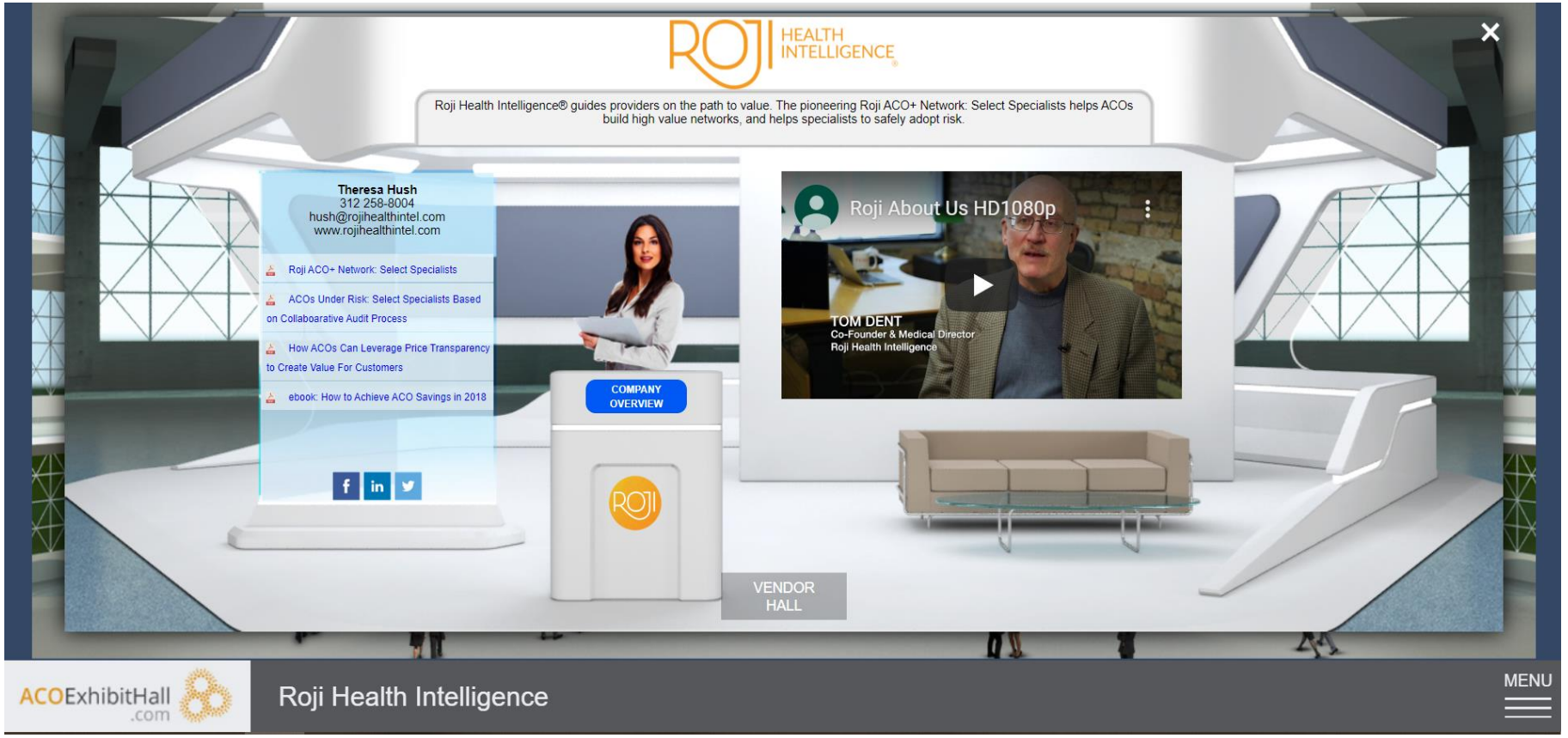

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Thank You

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