Accountable Care and Shared Savings Programs—where Do Urologists Fit in?

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What is Driving changes such as ACOs?

- The demographics are awful
  - 10,000 new Medicare patients per day
  - 40% of the population is obese
  - Life expectancy likely to continue to increase
  - Medicare & Medicaid together will consume 20% of GDP in 20 years
    [MCare $566B-$1.05T, MCaide $275B-$622B]
- We have finally reached the tipping point where everyone; the government, employers, payers, employees have all said “enough”. There is no where else to shift costs.
- The cost of health care is unsustainable.
We All Have to Change

- **Providers**
  - Improve outcomes and satisfaction
  - Decrease costs and waste
  - Coordinate care

- **Payers/Employers**
  - Encourage prevention and compliance
  - Value-based benefit design
  - Reward value

- **Patients**
  - Healthy lifestyles
  - Compliance
  - Financial stake

- **Government**
  - Ensure transparency
  - Pay for value
  - Help for those in need
  - Support research and education

*From Mayo Clinic Health Policy Center, 2010*

Today’s Reality is a “New World Order”

- The debate and passage of the Affordable Care Act have changed our industry forever
  - CMS ACO pilots are the catalyst
  - Commercial sector momentum is building in a clear direction
  - FFS unsustainable → accountable care
  - It’s going to be a bumpy ride
Medicare ACO: Where do the Patients Come From?

- Attribution/Assignment Models

  - Patients are attributed based upon historic frequency of visits to providers
  - Patients are attributed based upon episodes of care
  - A PCP must provide at least 80% of that patient’s care
Keeping track of attributed patients

- The patient has no choice. Attribution is based on who the PCP is.
- Patients can still choose to go where they may, yet they are still counted economically to the PCP they are attributed to.
  - This is a problem if the PCP cannot control the consumption of resources. Therefore, the PCP must convince the patient that they will get the best quality possible
  - Outliers are excluded from calculations

Physicians

- Primary Care Physicians must choose 1 ACO
  - Drives attribution
  - Potential Care Coordination Payments
- Specialists may be part of multiple ACO’s
Two Separate ACO Programs Run Out of CMS*

- Medicare Shared Savings Program (MSSP) ACOs
- Pioneer ACOs

*Centers for Medicare and Medicaid Services

SOURCE: Akin Gump Strauss Hauer & Feld LLP/SNR Denton

Snapshot comparison

- Pioneer ACOs
  - Fully funded (100 million dollars).
  - Experienced and financially robust participants
    - 32 selected from 80 applicants
      - IPAs such as MONARCH.
      - Hospital based such as U. Michigan
      - Physician led and hospital based such as Sharp in San Diego
      - Hybrid: Staff model plus IPA such as Healthcare partners
Snapshot comparison

• Pioneer ACOs continued
  – Minimum of 15,000 FFS Medicare patient lives
    • MONARCH (our IPA) has 17,000 patients with 275 PCPs
  – In 1st year 50% PCPs must be on same EHR
  – Full risk by 3 years
    • Outliers will be excluded from calculations
    • Benchmarks are derived from the participants own historical performance
      – MONARCH (our IPA) already has 1/3 less hospital stays so their benchmark will be regional.

Snapshot comparison

• Medical Shared Savings Program (newer)
  – Watered down version of Pioneer ACO
    • Experience and financial strength not required
      – CMS will loan money (against future payments)
    • 5000 FFS Medicare lives required to participate
    • 23 programs
      – 13 physician led
      – 10 hospitals
      – 10,000 physicians with 375,000 beneficiaries.
Snapshot comparison

- Medical Shared Savings Program
  - Shared Savings
    - Not likely to be “enough”, especially in mature markets
    - Good for entry level ACO’s, no risk
    - Still rewards FFS approach

Potential Payment Models

- Initial CMS experiment
  - Shares Savings/FFS approach
  - 10 programs: total savings **20 dollars per patient per year**
  - Lost savings may be due to increased granularity of coding for FFS reimbursements with each passing year of participation
Potential Payment Models

- Partial Capitation
  - Assures access to capital in advance
  - Resources required to be successful
- Global Capitation
  - Mature groups with experience in this arena
  - Risk

### Potential Payment Models

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### The Opportunity – An Example

#### Unaligned:
- Specialist-based, siloed delivery system
- Fragmented delivery of chronic care
- ER primary access point for after hours and urgent care
- Providers paid to provide services not manage care
- Payers manage performance through inspection

#### Fully Aligned:
- Primary care centered models
- Continuity of care provided through electronically connected system with dedicated care extenders (NP) assisting primary care
- Dedicated resources for chronic/after hours urgent care
- Performance-based payment system resulting in aligned incentives between stakeholders (payers and providers)

<table>
<thead>
<tr>
<th>Current State Performance: Typical Medicare Advantage Plan</th>
<th>Market Leading Performance: Benchmark Systems</th>
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<tr>
<td>Admits per 1,000 = 315</td>
<td>Admits Per 1,000 = 225</td>
</tr>
<tr>
<td>Inpatient Days per 1,000 = 1,500 to 1,700</td>
<td>Inpatient Days per 1,000 = 800 to 1,000</td>
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<tr>
<td>% of Recommended Care Received by Chronic Pts: 55%</td>
<td>% of Recommended Care Received by Chronic Pts: 95%</td>
</tr>
<tr>
<td>EMR/EHR Adoption = &lt; 35%</td>
<td>EMR/EHR Adoption = 70-80%</td>
</tr>
<tr>
<td>Patient Satisfaction = variable</td>
<td>Patient Satisfaction &gt; 96%</td>
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Reduce total cost by 15-20% while increasing patient satisfaction
Market Change Will Take Many Forms...

**Community by Community**

- Cumulative addressable market
- Global market risk model
- Professional services risk model
- Episode of illness payment
- Bundled services payment
- Fee-for-service

**Care Provider Practice Models**

- Sole practitioners
- Virtual community networks
- Independent practice associations
- Physician hospital organizations
- Multi-specialty group practices
- Fully-integrated delivery systems

New value creation for existing solutions; creation of new markets

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**The Monarch Experience**

- IPA formed in 1993 based in Orange County, CA
- Urology was the first specialty invited to participate with MONARCH with capitation
- Recently purchased by OptumHealth (subsidiary company of United Health Group)
- One of 5 California programs selected to participate in a Pioneer ACO
The Monarch Experience

• Ramping up to capitation
  – Initially urology contracted for discounted fee for service
  – After 2 years of discounted FFS at agreed-to rates we reviewed our utilization
  – Using meticulous records of utilization we derived our capitation rate

The Monarch Experience

• Capitated contract
  – We are responsible for 140 thousand lives
  – We have 10 FTE urologists
  – We subcontract to other urologists in areas we don’t physically cover
    • We negotiate FFS contracts with these other urologists
    • We service and pay their claims and keep profit if any
  – Monarch writes use ONE check
The Monarch Experience

- “Favored Nation” status
  - Urology represents <2% of the global budget for Monarch
    - Easy to stay off the radar for cuts and revisions
    - Show up, do good work and get the check
  - We are at FULL RISK excepting carve outs
    - Lupron and chemotherapy
    - Ultra complex cases
  - As our subspecialty skills have evolved we can take on more complex cases—renegotiate—win-win

The Monarch Experience

- The Monarch Pioneer ACO is underway
  - 17,000 lives attributed to 270 PCPs
- Shared savings are initially predominantly shared between Monarch and the PCPs
  - Attributed patients appear to OUR UROLOGY PRACTICE as traditional FFS patients UNTIL year 3
- Year 3, we shift to full risk-Capitated model with more direct realization of financial benefits/risks
The Monarch Experience

— Ready for Full Risk
— Data is King
  • We have a 17 year mature data base of millions of data points
  • We have a clear understanding of the numbers of new patient visits/procedures/return visits and the ratio of medicare to commercial patients that utilize these
  • This data allows us to confidently negotiate our compensation in an ACO

This can be a Win-Win

— LAB Business or “Retail spillover” concept
  • Referring physicians eventually send commercial patients to the same labs that they send contracted patients to and this is true for Urology referrals as well.
  • We can expect almost equal numbers of commercial referrals as we do contracted referrals as our competency shines through.
  • Even if an ACO model fails, the new referring physician relationship can endure
How to: Transitioning from FFS to Capitation

• Data is King
  – Keep meticulous records of utilization
    • Patients seen, procedures performed, supplies consumed (every catheter)

• Benchmark
  – Use Medicare as a benchmark to derive compensation for seniors’ utilization and use a dominant commercial carrier as a benchmark for nonseniors’ utilization
  – We have observed our ratio to be 4:1 seniors to commercial

How to: Maintaining capitation

• Distribution of compensation
  – Frame expectations by urologists in the practice:
    • Abandon “complexity” considerations: every new patient gets same “credit” and every return patient gets same “credit” – roughly benchmarked to Medicare and commercial FFS.
  – Don’t “credit” urologists in the group for items/procedures that cost the group money.
    • cultures, bladder scans, trays, etc
How to: Maintaining capitation

- Monitor internal consumption
  - Capitation can yield advantaged compensation versus FFS as long as utilization is not driven up
  - Develop a system to monitor utilization of capitated patients to prevent internal “gaming” of the system by urologists in the group
  - Establish a pool of money from the capitated payment that is a “set aside”
    - Overage above FFS benchmark
    - Split equally at the end as a “bonus”
    - OR may be used for “special circumstance” compensation

Narrow Networks: On the road to ACOs

- Not a “tiered physician network” which assigns physicians into two or more separate tiers, classic model for payers under their “in network” models for PPO patients
- A “narrow physician network” is a small or select network of physicians within a larger network
- Participants in a narrow network are selected based on “efficiency of care”; costs plus quality of outcomes
- In exchange for a narrow choice of providers [hospitals, physicians, ASC, imaging centers] employers and patients are offered lower costs for premiums and co pays

Employers are driving this trend

- Businesses increasingly are demanding insurers create networks that include some hospitals and physicians and leave others out. They are willing to give up choice for costs

- “Employers are saying,’Look, open access, choice, freedom of movement around the system, in or out of the system, was great when trend was manageable and the economy was good’. ‘Employers are willing to limit choice to create a better cost advantage’. Joe Zubretsky, CFO Aetna

- Large and small businesses are interested in narrow networks which seem like the solution to the dilemma facing employers: a way to make sure workers stay healthy, get high-quality care and save money.

Whose Participating

- Every major insurer has or is developing a narrow network insurance product. Small employers were the original target but increasingly it is being sold to large employers. It is being demanded by both the employer and the employees.

- Examples:
  - Banner Health, a health system offering care in seven western states, is offering an HMO product “Banner Health Network”. Under this plan employers will receive premium discounts estimated at 20% over PPO for limiting their network of providers to Banner Health.
  
  - Mayo Clinic Care Network
    - 3 major hospitals-Rochester, Phoenix, Jacksonville
    - 41 Clinics and Hospitals - Minnesota
    - 22 Clinics and Hospitals - Wisconsin
    - 5 Clinics and Hospitals – Iowa

  - CALPERS/CHW/BS/Hill Physicians
    - Saved $20 million 1st yr: $15 million to CALPERS, $5 million shared BS/CHW/Hill
    - Next years premium reduced 15% to CALPERS beneficiaries

  - Harvard Pilgrim-hospitals excluded, MGH, Brigham, high cost providers given option to lower fees couldn’t/wouldn’t
Narrow Networks: Positioning for Success

- Big groups are uniquely positioned to prove to payers that they are the most desirable partners
  - Scale
  - Sophistication
    - Subspecialty expertise prevents expensive outsourcing
  - Quality control
    - Internal and external benchmarking of utilization and outcomes (positive prostate biopsy rate)
  - Comprehensive cost containment
    - Leverage ancillary ownership. Incorporation of ancillary services saves money over hospital use.

Theory of *Consolidation*

- When the health care industry faces reimbursement pressure, the historic [and current] response is to get bigger to gain scale
- With Bundling, ACOs, readmission policies, vertical integration makes sense to control the continuum [again] and avoid the moral hazard
- Hospitals on a binge-
  - Vanguard buys Detroit Medical
  - Community acquires 10 hospitals and a large physician group
  - HCA bought remainder of HealthOne
  - HMA bought Mercy Knoxville [7 hospitals] and JV’d 5 more in OK
  - LifePoint’s Duke JV continues to acquire hospitals and assets
  - Tenet bought lots of in-market outpatient centers, not hospitals
  - Regional Care bought Essents through a merger
  - Ascension buys Marion Health
  - Mayo Clinic buys Northshore (Chicago)
  - Vanguard-Tufts
  - St Josephs buys Hoag
  - All are “acquiring” doctors through employment contracts
Conclusions

• The trends in health care expenditure mandate fundamental changes in the delivery systems
• The Pioneer ACOs will likely show which models work and which don’t
• FFS as we know it is likely to go away and be replaced by “Population Management” or “Bundled Episodes” just another name for CAPITATION
• Understand risk—don’t fear it.
• Eliminate the “FFS as Holy Grail” mindset. The premium of FFS over Medicare continuously declines.
• There will continue to be consolidation at all levels and very few “independent” private practices will survive. Most MDs will be employed and salaried by someone. Most market places will have no more than 3 integrated systems and many will have fewer
• Insurance companies will continue to reinvent themselves to remain relevant as large employers do direct contracting and insurance exchanges evolve for individual and small groups