Accountable Care Case Study: A Health Plan Perspective

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About Independence Blue Cross

- Based in Philadelphia
- Annual Revenues – $10 billion
- Contracts with approx. 35,000 providers
- About 4 million members across all lines of business and subsidiaries
- 5th largest Blue
Market Dynamics

- High cost/utilization
- Significant HMO/POS penetration
- Growing number of hospital-employed physicians
  - Private practice not financially viable  
    (especially primary care)
- Abundance of specialists, academics
- Limited group formation and “vertical” provider integration
- Historically limited/deficient performance-based incentive programs

Historical P4P Programs

- PCP and hospital focused
- Quality (process vs. outcome)
- Generic prescribing
- Patient satisfaction
- Provider satisfaction
- Questionable value and/or ROI
Historical Core Deficiencies

- Medical cost measures
- Professional outcome measures
- Specialist engagement
- Comprehensive care coordination
- Provider transparency/tools
- Nominal program value

Objectives: Program Development/Refinement

- Re-empower PCPs and address private practice viability
- Specialist engagement and commitment
- Incent vertical integration (and enhanced care coordination)
- Incorporate measures for improved efficiency/utilization
- Meaningful financial rewards, to drive behavioral change
- Alignment of PCP, specialist and hospital incentives
- Compliment payor and provider healthcare reform initiatives
Changes to Primary Care Incentive Model (QIPS)

• Quality (50% weight)
  – HEDIS measures - based on relative performance (14 tiers)
  – Patient Centered Medical Home (Levels I-III, per NCQA)

• Medical cost management (50% weight)
  – Professional/outpatient costs - based on relative network performance (4 tiers)
  – Generic prescribing – based on relative network performance (7 tiers)

Program Value: Over 100% of base reimbursement

Other Features – Primary Care Incentive Program

• Medical cost performance based on continuously enrolled population (11 months)

• Medical cost component excludes inpatient services, preventive care, maternity, mental health, hospice, high-cost claimants ($50K) and members under the age of two

• Practices in the bottom 25% percentile for quality are not eligible for medical cost management incentive payments

• "Tournament” model
Primary Care Physicians Reaction

- Overwhelmingly positive
- Significant provider engagement
- Actively pursuing/requesting education
- Many taking advantage of the PCMH subsidy
- PCPs anxious to gain access to comparative tools

IBC’s Accountable Care Payment Model (IPPIP)

- Quality (50% weight)
  - CMS appropriate care measures: All-Payer Data (12.5%)
  - Hospital-acquired infection rates: All-Payer Data (12.5%)
  - Re-admission rates: IBC data utilizing on 3M’s “PPR” methodology (25%)
- Medical cost management (50% weight)
  - Medical cost targets (based on “allowed” cost)
  - HMO/POS assigned population adjusted for risk, unit cost trends, PCP additions and terminations and material changes in DXCG risk score

Program Value: Varies - % of annual spend (significant)

Note: Unlike the primary care incentive program, all quality and medical cost measures in the accountable care payment model are tied to customized baseline performance improvement.
Accountable Care Payment Model (cont.)

- Open to all eligible legal entities
- No initial downside “insurance” risk to providers, although risk-sharing can be accommodated
- Medical cost performance based on continuously enrolled population (11 months)
- Medical cost component excludes mental health, high-cost claimants ($150K)
- Medical cost incentives are subject to minimum quality standards (i.e., payments reduced if standards are not met)

Accountable Care Payment Model (cont.)

- Quality component measures both “annual” improvement (over prior year) and “total” improvement
- Full credit is given for “superior quality performance” regardless of % improvement (90th percentile, nationally)
- Provider entity must develop and submit a performance improvement plan prior to accountable care implementation
- Medical cost “surplus sharing” percentage is based on the degree of improvement (30-50%)
- If the eligible provider entity is a hospital-sponsored, it is required to share at least 33% of any surplus with its physicians (50% recommended)
**CMS ACO vs. IBC’s Accountable Care Payment Model**

<table>
<thead>
<tr>
<th>Feature</th>
<th>CMS</th>
<th>IBC</th>
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<tbody>
<tr>
<td>Accountable for quality, cost and overall care</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Organized legal entity with an ability to distribute gains</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Patient population based on PCP membership/attribution</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Promotes clinical care coordination via vertical integration</td>
<td>✓</td>
<td>✓</td>
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<td>Incorporates “patient-centeredness” criteria</td>
<td>✓</td>
<td>✓</td>
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<td>Effectively aligns incentives across the care continuum</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Value-based reimbursement model</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Shared savings methodology (i.e., no initial insurance risk)</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Quality improvement incentives via self-reported data</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Medical cost reduction incentives</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Performance monitoring and data reporting capabilities</td>
<td>✓</td>
<td>✓</td>
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**Provider Enablement**

- **Technology Partnership**
  - Provider-based tools
  - Clinical info + claims data = Actionable information at the point of service

- **Provider Transparency Initiative**
  - Cost Comparison Tool: 175 high volume IP & OP services
  - Aggregate unit cost indices – IP, OP, Commercial, Medicare

- **Dedicated Support Team** (actuarial, finance, medical director, etc.)
Program Results

• Good News
  – PCP model accepted by 95% of practices
  – ACO model embedded in 85% of hospital/health system agreements and 100% of IPA agreements

• Not So Good News
  – Limited investment in provider infrastructure
  – Nominal hospital and specialist engagement
  – Not sure where to start
  – Lack of “know how”
  – Hospitals conflicted

Do the math...

Total Savings: $10,000,000
Health Plan 5,000,000
Hospital 2,500,000
Physicians 2,500,000
Preliminary Conclusions

• Hospitals stand to lose the most in an era of efficiency and many remain focused on revenue concerns

• Health plans must find a way to distinguish themselves among their competitors, and in most markets, the elimination of unnecessary utilization will be a much more powerful lever than unit cost

• Primary care physicians, if empowered, stand to gain the most

• As a result, many health plans have adopted a primary care-centric performance-based approach (but like-minded specialists and hospitals can certainly benefit and prosper)

So What's Next?

• Continue to support existing ACO payment model participants

• Explore alternative physician-centric partnership opportunities

• Develop and deploy a much broader "provider enablement" strategy
Q & A