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Next Steps for Accountable Care: What's on the Horizon

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Overview

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- *Disruption drives integration*
- *ACO Facts and Results*

2. What's Next for Medicare ACOs

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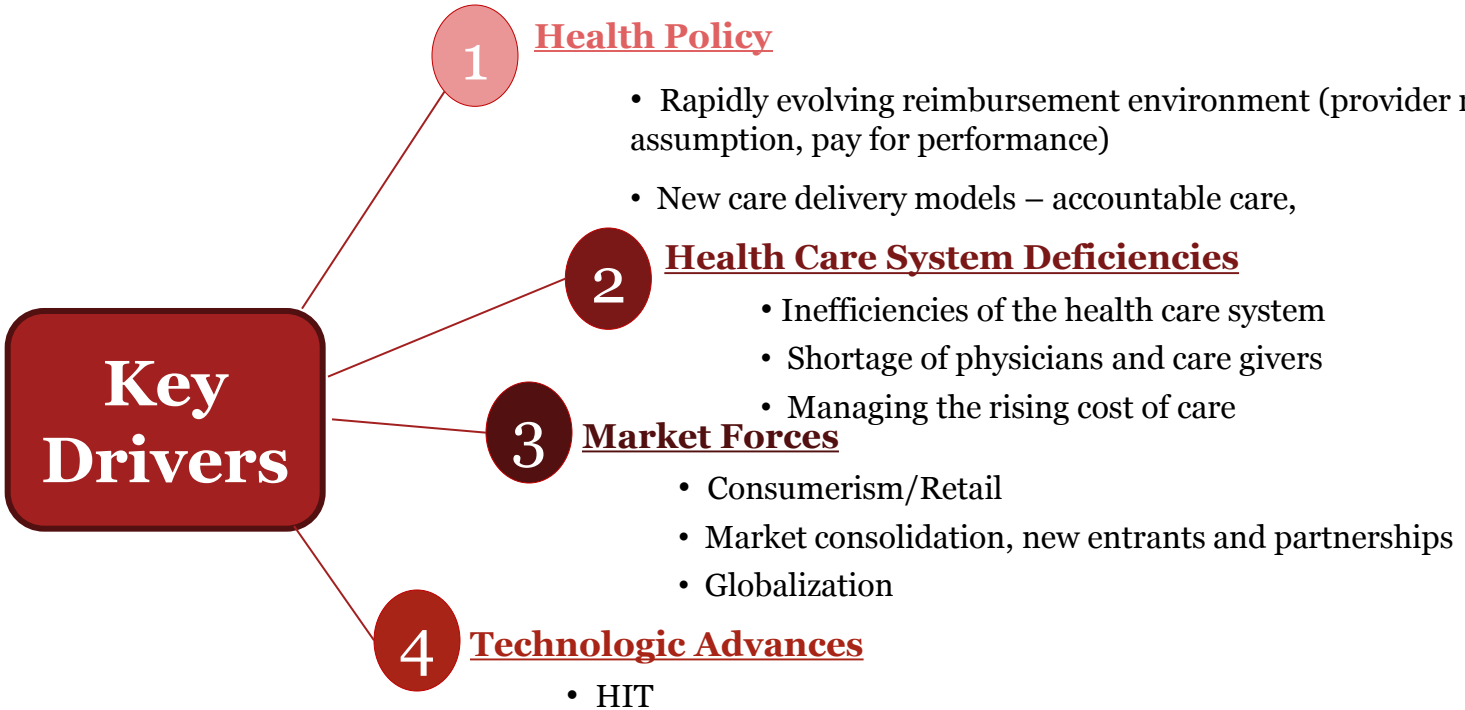
The Marketplace

1

The US healthcare system is facing unprecedented market disruption

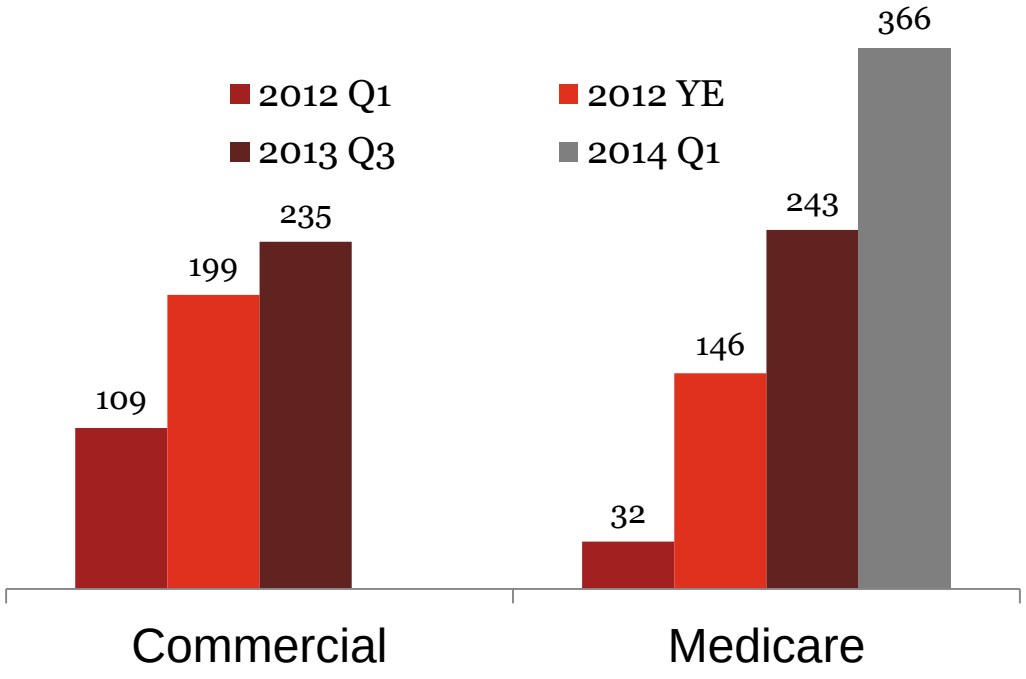
Public policy and market forces are combining to drive market integration



And providers are increasingly turning to accountable care and the development of end to end service networks as a survival strategy

123 new Medicare ACOs came on board in January bringing the total of Medicare and non-Medicare ACOs to over 600

Commercial and Medicare ACO Growth



ACO FACTS

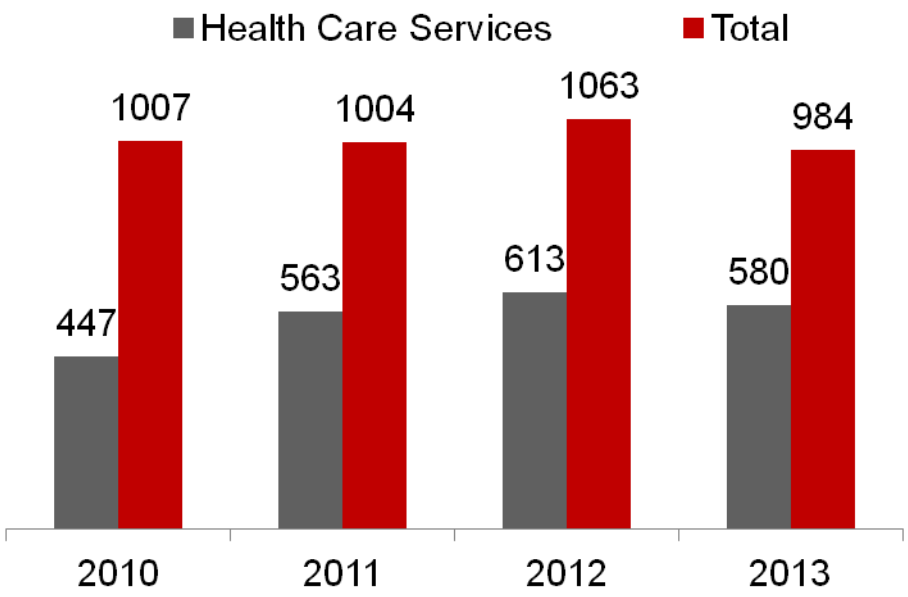
- ACOs are now available in all 50 states
- Medicare ACOs cover approximately 5.3 M beneficiaries
- The total number of covered lives in both commercial and Medicare ACOs tops 18.2 million
- Very few ACOs now accept two sided risk

Source: Center for Accountable Care Intelligence "Growth and Dispersion of ACOs: August 2013 Update"; 2013 Medicare numbers modified to be consistent with September, 2013 MedPAC presentation , *Medicare Accountable Care Organizations: Recent Developments and Future Directions; 2014 numbers include 123 ACOs announced by CMS in December, 2013*

Creative partnership arrangements and mergers and acquisitions are facilitating the development of comprehensive networks

M & A activity in the health care services sector is increasing as a percentage of total industry M & A

Total Health Care Industry and Health Care Services Mergers and Acquisitions by Year



- Will the recent Idaho court decision dissolving the St. Luke's and Saltzer Medical Group merger impact future ACO development?
- Similar arguments are being raised in Boston, Pittsburgh and Northern California, where hospital systems have gained strength through acquisitions of doctors' practices and other hospitals

Source: PwC US health services deal insights: *Analysis and trends in US heath services activity in 2013 and 2014*, March, 2014; data on deal volume per year is from *The Health Care M&A Information Source*, www.healthcareMandA.com

Although first Year Pioneer ACO performance results are mixed, they show significant improvements over first year PGPD results

Pioneer ACO 1st Year Results

- All Pioneer ACOs achieved the maximum quality performance rate in year 1 and performed better overall on 15 quality measures than Medicare FFS
- 13 of 32 Pioneer ACOs achieved Shared savings
- 2 ACOs shared losses totaling $4M
- 17 were below threshold for sharing
- 9 of 32 pioneer ACOs are leaving the program prior to year 3 (7 will transition to the MSSP)
- Overall, the rate of cost growth for Pioneer ACO members was less than costs for similar FFS beneficiaries (.3% vs. .8%)

PGPD Results

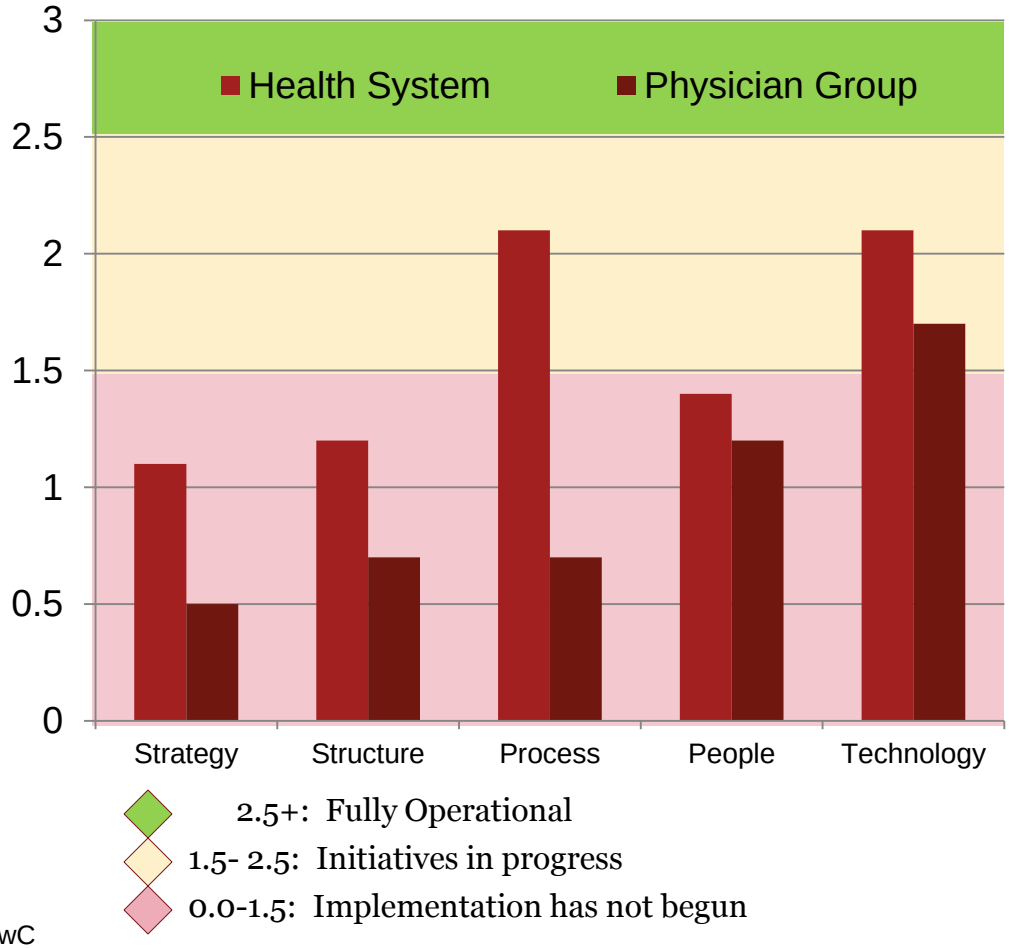
	% of plans attaining > 90% of quality goals	% of plans receiving shared savings payments
Year 1	60%	20%
Year 2	100%	40%
Year 3	100%	50%
Year 4	100%*	50%

Only 2 PGPD plans received shared savings payments in all 4 years. 2 plans achieved 100% of quality goals in 2 separate years but never qualified for shared savings during the 4 year period, and 2 others achieved 100% of quality goals in years in which they did not qualify for shared savings.

* Source: MedPAC, *Medicare Accountable Care Organizations: Recent Developments and Future Directions*, September, 2013

But, readiness challenges continue to plague newly developing ACOs

PwC experience reveals that strategy and structure development are major gaps

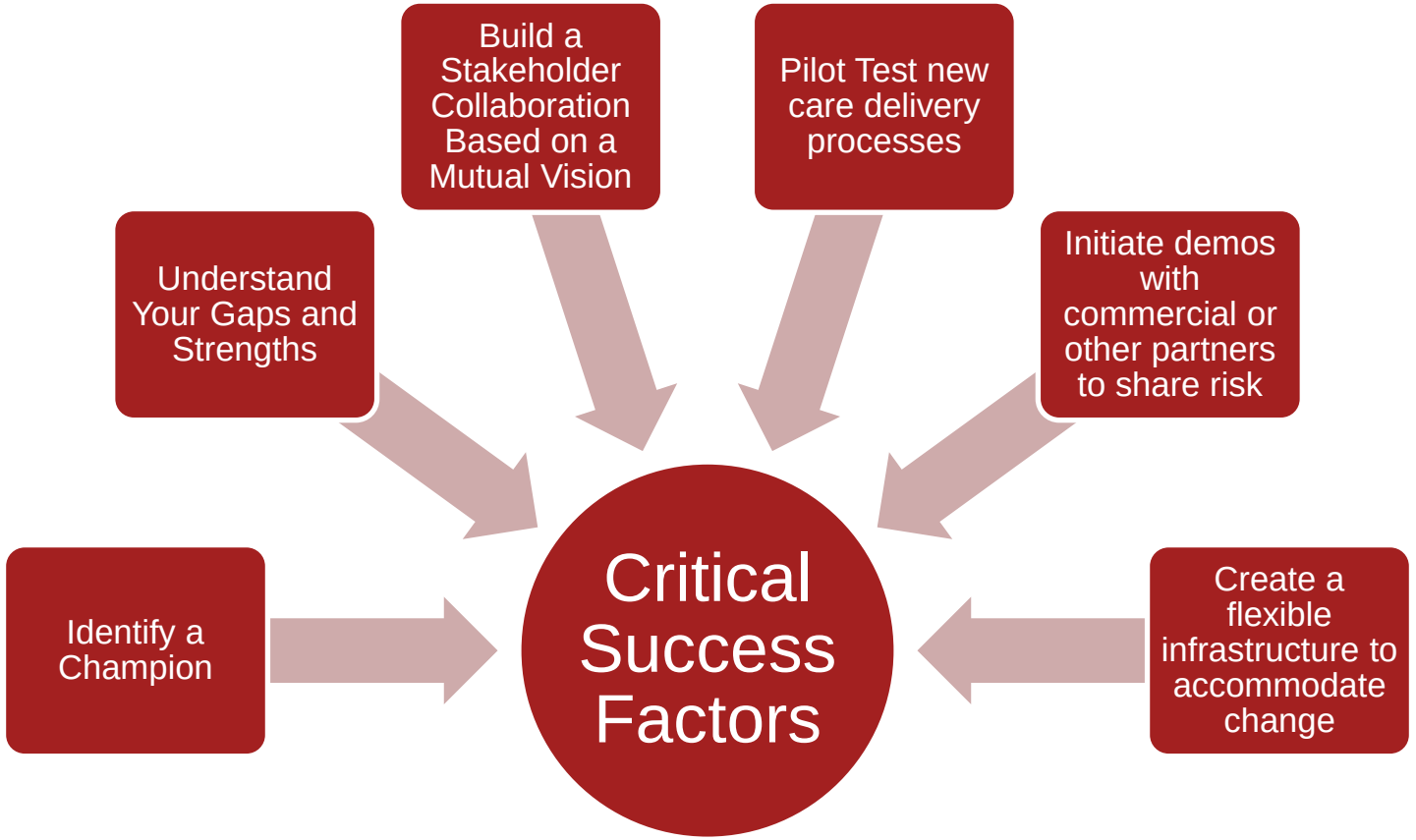


Major Gaps

- Designing ACO organizational models and governance structures
- Identifying appropriate leadership and management
- Developing a quality assurance and compliance process
- Documenting how the organization will use shared savings payments
- Communicating the strategic goals and vision of the ACO and the expectations of stakeholders
- Developing communications plans to establish the brand

The following components are often overlooked and are essential to ACO success

PwC findings from ACO development experience



Stakeholder alignment is the critical foundational element

Achieving shared savings, while not easy, is not impossible
A Pioneer ACO Success Story

About the Client

- An established non-profit health system with 14 hospitals and 700 physicians covering 4 service areas in 3 states
- Established a Pioneer ACO in 2011 in one of 3 states

The PwC Relationship

- PwC had a solid partnership with the client over the course of 15 years assisting in:
  - Developing and implementing strategies related to physician engagement, alignment and integration
  - Developing an integrated heath care delivery system that served as the basis for the ACO framework

A Pioneer ACO Success Story (Continued)

The Project and Results

The Project

- To develop a successful Pioneer ACO strategy and organization capable of achieving value at the level required for shared savings success in a select geography

The PwC Role

- PwC assumed a broad role in supporting senior leadership including:
  - Assisting with stakeholder engagement and gaining board approval
  - Conducting readiness assessment and gap analyses
  - Designing care management model
  - Providing analytic support and necessary financial analyses across various payment tracks
  - Serving as lead interfacing with CMS policymakers

The Results

- Client selected to be one of 32 Pioneer ACOs from 80 applicants
- After first year results, client ranked in top 5 Pioneer ACOs
  - Achieved over $13 M in cost savings
  - Qualified for over $6.5 M in shared savings

Post Project Initiatives

- Client joined with multi-specialty physician practice to form an MSSP ACO
- Client developing a Regional ACO strategy

What's Next for Medicare ACOs

2

First year Pioneer results have raised a number of issues about the Medicare ACO program

A majority of these issues are also relevant to the commercial market as well

- Should beneficiary assignment be based on spending or service use?
- Are changes to the beneficiary notification and opt-out processes needed?
- How can out-of-network utilization be managed?
- Should benchmarks and risk adjustment methodologies be re-evaluated and the playing field leveled with MA?

- How will metrics change over time?
- Should metrics and methodologies across FFS, MA, and ACOs be the same?

- Are incentives large enough?
- How much do savings need to grow to justify costs?
- Will savings increase over time?

Is the Program sustainable from a provider perspective?

As the expiration date for the first 3 year contracts approaches (1/2015), a number of changes are under discussion at MedPAC

- Establishing benchmarks based on service use
- Assignment based on care provided by RHCs, FQHCs, non-physician providers
- Establishing beneficiary incentives (Lower in network cost sharing)
- Quality scoring moves to more outcomes based measures
- Movement toward common quality measures for ACOs, MA, FFS
- Other Changes to assignment methodology
- Risk Adjustment
- Develop Medicare Select ACO product

In the longer term, the playing field will become more level across Medicare products

Benchmarks and risk adjustment methodologies will undergo modification

Benchmarks

- ACO Method - ACO beneficiaries historical experience, actual trend
- MA Method - FFS baseline, projected trend (MA method)
- MA benchmark from 95 to 115% of local FFS

Risk Adjustment

- ACO Method – Historical spending baseline
- MA Method – Hierarchical condition categories

Also on the horizon is the bi-partisan "Better Care Lower Cost Act of 2014" to encourage team based care with rewards for outcomes

The Better Care Program (BCP) targets the chronically ill and differs from the current ACO model in several ways

	ACOs	BCPs
Payment	ACOs operate under a FFS system and may be eligible for shared savings	BCPs are paid a set amount for each enrolled beneficiary
Attribution	ACO providers are subject to attribution which prevents them from targeting and enrolling the sickest patients	There are no attribution rules
Benefit Design	No limits on where a patient can seek care outside the ACO and few incentives to stay within the ACO	BCPs can lower cost-sharing on services that provide the most value for an enrollee's condition
Individual Care Plan	ACOs are not required to create an individual care plan for each beneficiary	Every beneficiary has an individual care plan
Targeted Enrollment	ACO model does not differentiate between beneficiaries care needs preventing focus on chronically ill	BCPs are designed to target chronically ill beneficiaries

In December, CMS released an RFI related to the evolution of the ACO program

The RFI proposes changes to Pioneer ACOs and MSSP ACOs

The Pioneer ACO Program

- **Potential second round of applicants** for the Pioneer Program
- **Refining the population-based payment model**

Encouraging Greater Care Integration & Financial Accountability

- **Transitioning to greater risk** such as capitation payments similar to MA plans
  - *Issues: Services covered, carve-outs, state licensure, infrastructure requirements, risk adjustment model, setting capitation rates, potential benefit enhancements, beneficiary protection from marketing abuses, voluntary beneficiary assignment vs. attribution*
- **Integrating Accountability for Part D**
  - *Issues: Data availability, barriers to effectiveness of collaborations with sponsors, interest*
- **Integrating Accountability for Medicaid Outcomes**
  - *Issues: Defining the population (only over 65?), role of States, data integration capabilities, integrated payment structure*
- **Other Models**
  - *Options: Provider led community ACO responsible for a geographic area; Combining service delivery and payment reform initiatives (a layered model); Multi-payer alignment of payment incentives and quality measurement*

ACOs: The End Game

3

There has been much speculation that ACOs are a transitional product

A transformation from provider to payer is underway, and it is the next logical step as ACOs mature and assume greater risk

Factors Contributing to the Provider to Payer Transformation					
New entrants and Exchanges have disrupted historical purchasing channels reduced role of brokers which has been a key barrier to entry	More educated consumers now expect *transparency and control* of their care services and corresponding data	The formation of ACOs, narrow networks and pay-for-performance means *providers are already assuming risk*	Providers are increasingly assuming risk through *Medicare ACOs, Medicare Advantage* and Medicaid managed care offerings	The formation of *end to end systems with significant breadth of services through acquisitions and alliances*	The increasing localization of the *delivery of care* based on the interaction across the key stakeholders

Many mature health systems are already performing much if not most of the work of a payer but without the rewards

Current Challenges

- If a health system reduces its costs, payers primarily benefit
- Systems need to be payers to capture locally the benefit of "profit" from lowering costs

Critical Factors

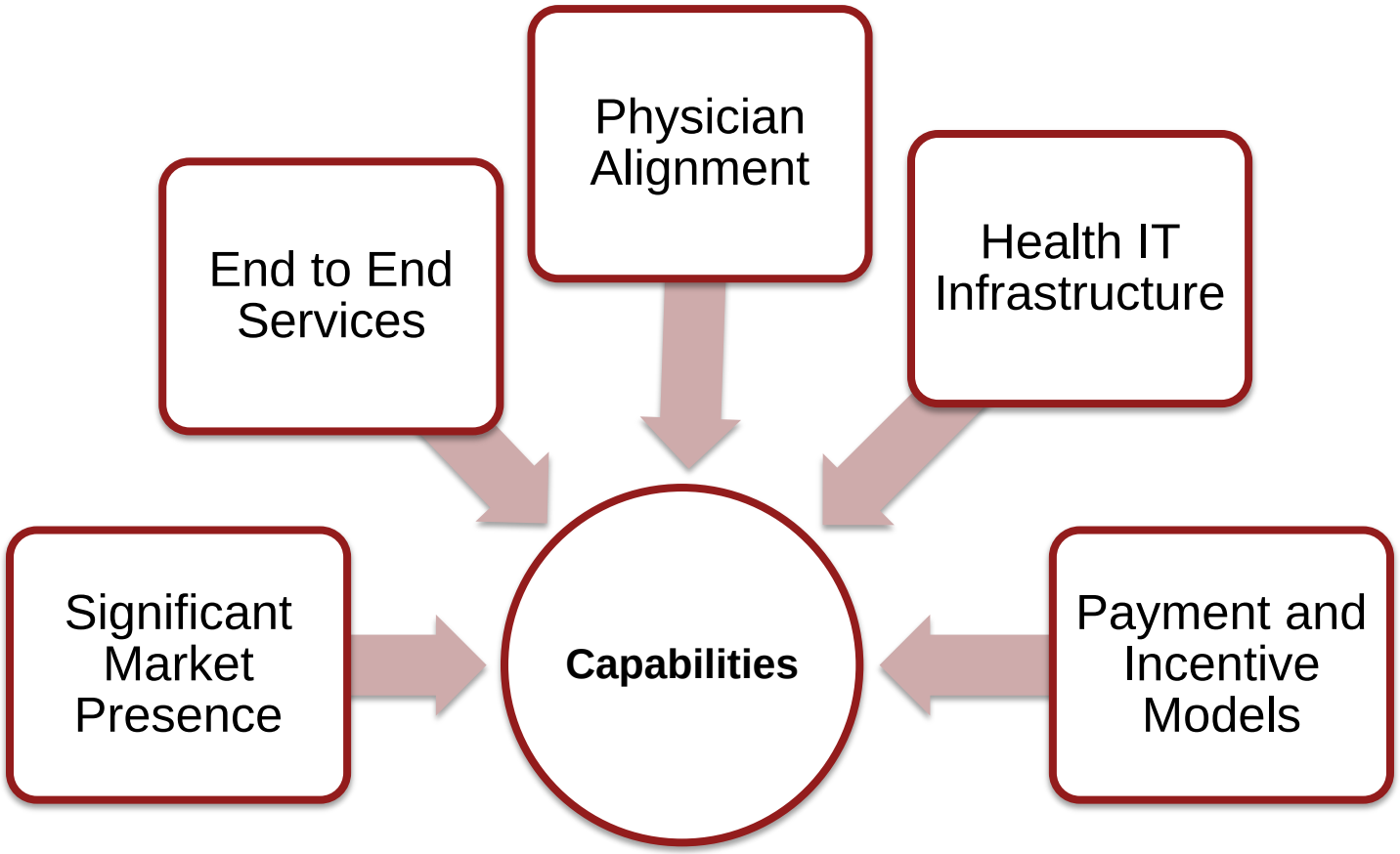
- Health systems have care management, HIT and other needed infrastructure in place
- The system can orchestrate the entire delivery and financing of care
- A provider-sponsored plan combines both claims and clinical data and potentially in real time creating a better platform for analytics
- Physicians and caregivers are more trusted and respected by consumers than payers generally

Outcomes

- More control of the premium dollar and financing
- More control of patient care
- The creation of a platform for other diversified markets and products such as MA, Medicaid managed care, dual eligibles, and direct services to employers both insured and self-insured

As ACOs mature, they will be well positioned to take advantage of the opportunity to develop their own heath plan

5 things provider systems will need to enter the payer marketplace



Today, there are more than 100 provider sponsored health plans in the country, and predictions are that 1 in 5 health systems will have their own health plan by 2018

Examples

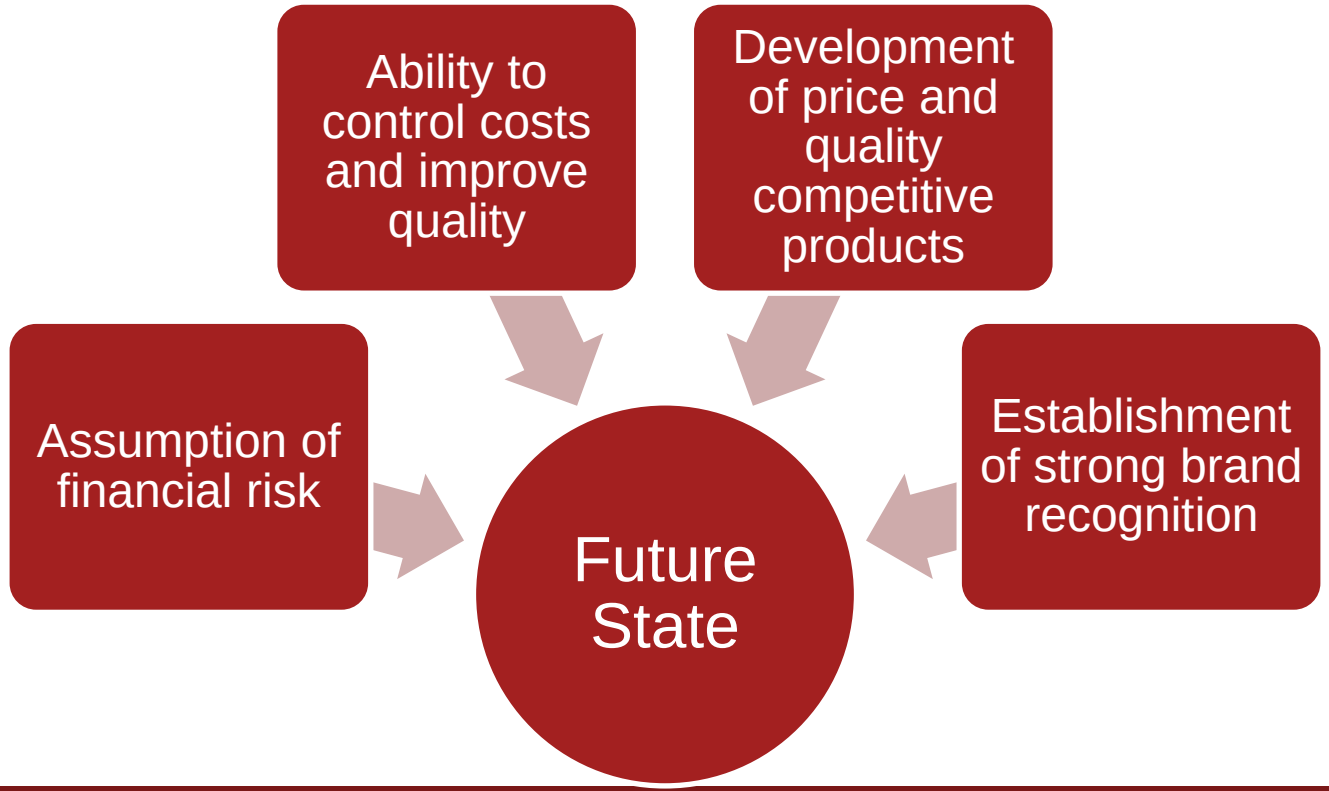
- Detroit Medical Center acquires ProCare Health, a Medicaid Managed Care Plan
- North Shore – LIJ launched its health plan
- Madison Wisconsin dominated by 3 provider-sponsored plans: Dean Health Systems, Meritor and Group Health
- Partners Health Care Systems acquired Neighborhood Health Plan
- Many health systems and large practice groups throughout the country are seeking HMO licenses and offering insured products and ASO products to self-insured employers (Will HIXs be next?)

Potential Issues

- Reaction of other payers
- How to resolve the dilemma of are you a provider or payer? Fill beds on FFS reimbursement or be price competitive as a health plan?
- How to compete with the national plans? Will a provider sponsored health plan have the “bandwidth”?

As large provider networks move into the health plan space, their priorities will change

The transition from negotiating with insurers to marketing to consumers will necessitate the following changes



The result – a decrease in historic consumer price increases resulting from market consolidation

PwC Case Studies

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The Provider to Payer Transformation – Case Study 1

A large integrated healthcare system seeking to develop a comprehensive insurance division

Business Problem	The Project
• A large Eastern system consisting of many hospitals, a network of employed and independent physicians, and other components of comprehensive delivery including ambulatory and post-acute facilities engaged PwC to assist in the stand-up of a broadly based insurance division including a licensed health plan, an insurance company, TPAs, and a broad network of providers. The insurance division is pursuing a variety of products and population opportunities, including participation in public and private exchanges, fully insured commercial accounts for both group and individual, self-funded employers including the system's own employees, Medicare Advantage, managed care Medicaid, and dual eligible populations.	• PwC is assisting the client via PMO services and a number of work streams including business strategy and cost of care, organizational structure and governance, physician alignment and network development, provider incentivized compensation, medical care management, Ops/HIT, government program strategies, and marketing/customer engagement. • PwC, working with the client, leveraged an integrated approach for the delivery of services by including clinical operations, financial, and strategy specialists as the core engagement team. • Our PwC team, with its experience in government and commercial products combining the perspectives of both provider and payers, is assisting the client to transform from a culture of a pure fee-for-service provider organization to an integrated payer-provider system sharing risk. This is allowing the client to better understand the challenges it is facing and the strategies and tactics to achieve its transformational objectives.

The Provider to Payer Transformation - Case Study 2

Building a Statewide Integrated Health Plan for a Regional Health System

Business Problem	The Project
• Our client, facing a rapidly-evolving health insurance landscape and a highly concentrated regional health plan market, sought assistance in devising a strategy to develop a statewide integrated health plan. • Priorities and assumptions about timing, costs, product/customer segments, and governance differed between the health system and health plan stakeholders. • PwC was engaged to provide an informed view of the Client's options, market potential, and to help internal stakeholders articulate a common vision for the joint entity .	• Aligned parties on shared vision for the offering, including markets, channels, and operating structure. • Conducted market analysis to assess opportunity based on geographic footprint, existing competitors, business line projections and policy considerations. • Quantified expected capital and operating expenses associated with initiatives needed to bridge gaps. • Built expense estimates into a financial model to assess venture's feasibility, key operating considerations and a 100-day plan of priority actions.