Plan Management Navigator
Analytics for Health Plan Administration

Healthcare Analysts

Douglas B. Sherlock, CFA
sherlock@sherlockco.com

John Park, CFA
jpark@sherlockco.com

(215) 628-2289

Benchmarks for Accountable Care Organizations: Observations of the Trial Stage

Introduction

Sherlock Company is creating cost benchmarks for Accountable Care Organizations (ACOs) and Clinically Integrated Networks. (In this *Navigator*, we will refer to both as ACOs.) Our process is occurring in two stages, a "trial" and a "live" stage. As we approach the end of the trial stage, we thought it might be helpful to share the results of what we learned.

If your ACO is interested in participating in the "live" stage of the benchmarking study, let us know. We expect to begin in the next few months.

Background

According to the Centers for Medicare and Medicaid Services, "Accountable Care Organizations are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high-quality care to their Medicare patients. The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors." While they incur operational costs to achieve this efficiency, no information is available to determine whether their efforts are themselves efficient. The Sherlock Benchmarks are intended to overcome this deficit.

Medicare encourages these organizations by rewarding them for their efficiency. The two different models are the Medicare Shared Savings Program and the Advance Payment ACO Model.

We sought select organizations to participate in the trial stage. The two organizations participating in the trial stage are part of Medicare's Shared Savings Program. They each served approximately 100,000 people in 2016 with a mix of Medicare, Commercial Insured, Commercial Administrative Services Only and Medicaid. Medicare dominates one of the ACOs, with the balance split between Commercial insured and self-insured. In the other ACO, Medicaid and Medicare are about equal and collectively dominate the member mix but it also serves some commercial insured members. Over 400 ACOs serve the Medicare program. These two ACOs appear to be in the top 10% in service to Medicare.

Method

To make certain that the resulting live benchmarks would be meaningful to ACOs, we have conducted a trial stage of the of the ACO Benchmarking Study. The Trial Stage was designed to hone metrics of the financial and operating characteristics of Accountable Care Organizations. This enabled the development of survey materials and reports that accurately capture characteristics that, when compared, illuminate best practices for ACOs. The focus of our analyses was administrative activities, but it also embraced health care organized by ACOs.

The trial stage addressed several related challenges. First, the precise scope of activities of each ACO was likely to vary between the organizations, and vary from organizations outside this sector. Second, because a benchmarking study of any kind requires a degree of uniformity of classifications and definitions, some preliminary taxonomy had to be established if only to provide a basis for ACO reaction. Finally, arranging the activities into the preliminary classifications requires knowledge of the classifications and a nuanced understanding of how each ACO differs in how it specifically executes the mission that it shares with its peers. To solve these challenges, Sherlock Company assumed responsibility for the preliminary classification scheme and the population of the ACO survey forms necessary for classification.

During the trial stage, the two ACOs provided information about their activities in highly granular form. Our inquiries included member months by population served, (sometimes referred to as "attributes" for Medicare beneficiaries), cost information and revenue information by customer, such as Medicare, Medicaid and Commercial. The cost information was sometimes in the form of cost centers, specific employees and their compensation, other information or a combination of sources. All costs were investigated to understand their activities relative to the ACO mission.

As a preliminary taxonomy for the trial stage, we employed the Sherlock Benchmark classifications for the administrative expenses of health plans. Their common activities and population-related costs made this convenient. Because of similar ownership profiles, the Independent / Provider – Sponsored ("IPS") universe was especially applicable.

Population Focus

A key determinant of costs for ACOs is likely to be the mix of the population that it serves, so we segmented costs by product in the trial stage. Medical management, such as disease or case management, is an example: senior Medicare beneficiaries require more health care and accordingly more medical management than younger people.

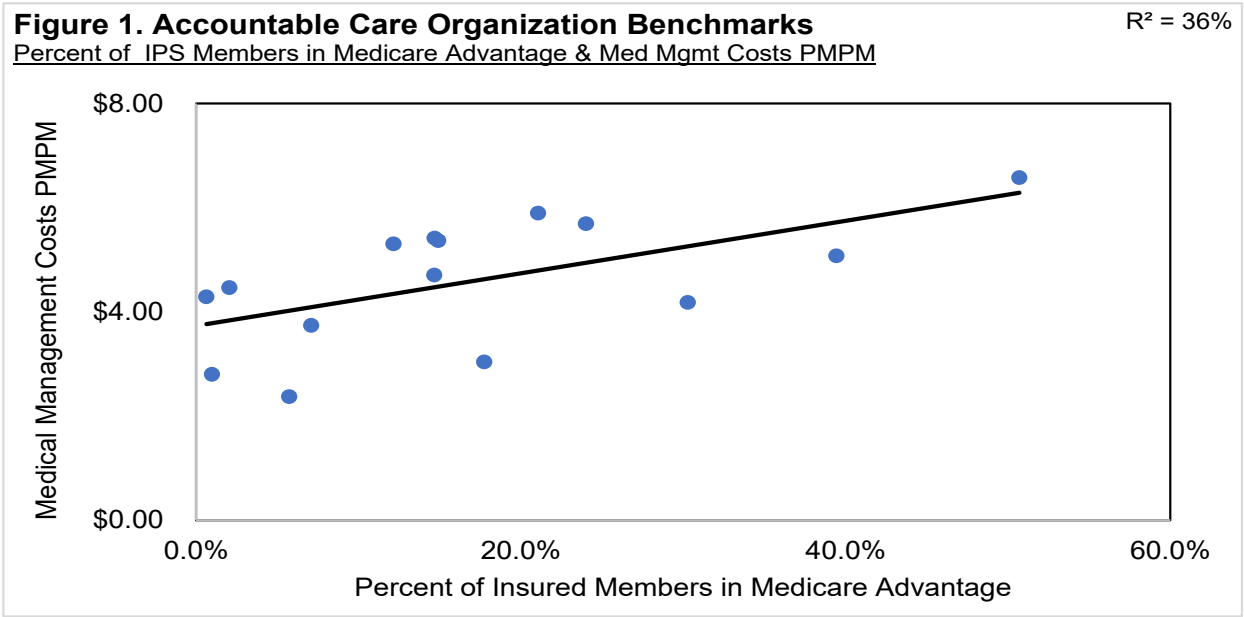
The IPS plans likely share this cost driver with ACOs. Figure 1 shows that the greater the share of Medicare, the higher the PMPM costs of Medical Management. The R^2 is 36% (P-Value 1.8%), indicating that percent of the cost differences are explained by that population factor. This is especially important since managing seniors covered under Medicare is often the most important activity of ACOs.

In the trial stage, we assumed the resource requirements of the ultimate users of the services of both ACOs and health plans, the consumer himself, varies by the characteristics of the served population. Costs were accordingly allocated by product. One of the ACOs did this for itself, while we allocated the other ACO's costs. Where the ACO performed this allocation, it first determined weights of its payors by reimbursement effort. The payor weights were then added and allocated to the appropriate products. Where we performed the allocation, we heavily weighted administrative expenses by the health care costs borne by each population served by that product.

ACO Activities

We have found that medical management and information systems are central to ACOs. Supporting them are various corporate service activities like corporate executive, finance and accounting, legal, facilities and so forth. Subcategories of medical management include case management, disease management, utilization review, medical informatics, quality components and so forth. Though not designed for them, each of these activities are detailed in the Sherlock Benchmarks for health plans and therefore applicable to ACOs.

Figure 1. Accountable Care Organization Benchmarks
Percent of IPS Members in Medicare Advantage & Med Mgmt Costs PMPM



Because we were preliminarily using the health plan classification system, we also identified many areas that are not found in ACOs. Unlike ACOs, health plans insured products are fully at risk for members' health care costs. The absence of claims adjudication and the associated infrastructure is especially notable.

ACOs also have very little interaction with individual consumers and instead focus on the health plans and other payors who reward them for their efficiency. Accordingly, functions such as enrollment and customer services are essentially absent.

Similarly, ACO Sales and Marketing is relatively modest on a per member basis. That is because they market to health plans and other payors. This difference between ACOs and health plans is analogous to the difference between Administrative Services Only products and Insured products in health plans in which the greater size of the self-insured groups means that their per member Sales and Marketing costs are less.

Common Ownership

For the trial stage, we compared each ACO with a universe of Independent / Provider – Sponsored (IPS) health plans. Both IPS plans and ACOs are usually owned by hospitals, health systems or physicians. This universe of health plans is, for lack of a better word, culturally focused on managing care.

ACO Results

Normally *Plan Management Navigator* provides a summary of cost values. Please see our Late June and July editions for cost values for Blue Cross Blue Shield and Independent / Provider – Sponsored plans, respectively. At this time, we decline to report values for ACOs for several reasons. First, at two ACOs, the trial stage of this set is too small to be meaningful. We hope to remedy the size problem when the live analysis is published in the coming months. Second, because the product mixes are quite different, the central tendencies of the unadjusted values are not meaningful. Finally, because we are still in the trial stage, it is possible that we have data definitions to refine.

We cannot generalize based on two self-selected ACOs, but what we found is nevertheless notable. Importantly, these observations are based on comparisons after reweighting the Independent / Provider – Sponsored health plan universe's costs to match the product mix of the population served by each ACO. By eliminating the effect of product mix differences, we illuminate actual operational differences. In fact, we found that product mix greatly affects overall cost comparisons between the two ACOs. Cost differences between the two ACOs were much smaller, measured as variances from mix-adjusted IPS costs, than without the adjustment.

After this adjustment, the overall costs of ACOs are less on a per member basis than IPS plans. ACOs do not have many of the costs found in health plans but emphasize Medical Management and Information Systems which dominate the cost structures of these organizations.

Sales and Marketing. This cluster of health plan expenses was largely absent from the ACOs. A small amount of activity remained in ascertaining health in the Rating and Underwriting area. The Sales effort was confined to allocations of employees with other responsibilities who, from time to time, called on insurers and other payors. Advertising and Promotion consisted of a small amount of public relations and media and advertising. Marketing and External Broker Commissions were entirely absent.

Medical and Provider Management costs were lower, with Provider Network Management and Services being especially low. Since these organizations are typically owned by providers, the network development and service are naturally less. Medical Management costs were also low but to a lesser extent.

The two trial-stage ACOs have somewhat different models. One has a hands-on approach to care management while the other appears to delegate this, supplying protocols to be implemented by the providers who directly manage these activities. Somewhat simplified, the former emphasizes Case Management while the latter emphasizes Disease Management. Lower staffing ratios were the principle driver of the lower costs in both functions.

Account and Membership Administration expense was significantly lower. The functions of Enrollment / Membership / Billing, Customer Services and Claim and Encounter Capture and Adjudication were essentially absent while Information Systems was lower. Information Systems, along with Medical Management the dominant costs and staffing for ACOs. Lower staffing ratios were the chief reason for the lower Information Systems costs.

Corporate Services costs were also much lower. The Actuarial area was nearly absent. Finance and Accounting and Corporate Services functions were lower chiefly on a low staffing ratio. Corporate Executive & Governance was lower than average for IPS plans but not by quite as much.

Towards the Live Stage

In the next few months, we expect to launch the live stage of the ACO benchmarks. We invite your participation. The following outlines our expected next steps:

1. Review content with Trial Stage ACOs.
2. Refine the survey instrument to reflect activities and data definitions of Accountable Care Organizations.
3. Develop Live Stage panel.
4. Develop format for Reports. Anticipated reports are:
    a) Comparisons by product.
    b) Comparisons by function.
    c) Compensation comparisons by function.
    d) Staffing ratios by function.
    e) Outsourcing by function, measured in FTEs and costs.
    f) ACO Characteristics
    g) Ranking in total and by function, after eliminating the effect of differences in population mix.
    h) Contribution of each function to total variance, after eliminating the effect of differences in population mix.
    i) Contribution of the factors of staffing ratio, compensation per FTE and non-labor costs to each functional difference.

While we expect the reports to provide valuable insights, we expect that the results will provide a basis for communication *between* the ACOs to improve operational performance. This may allow participating ACOs to reach out to superior performers in functional areas of their interest if the participants choose to communicate with each other.

We expect that from when surveys are distributed to when the reports are published will entail (as opposed to effort) approximately three months – six weeks to complete the survey form, one month of data validation and two weeks of report writing.

If you have an interest in participating in this study, please let us know. Similarly, if you have ideas that you think would enrich the study, you may count on our complete attention.