

Advancing Accountable Care

New Models of Care Workgroup
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ACO Core Principles and Key Design Features

Patient Attribution to the ACO

Measuring Financial Performance (Shared Savings)

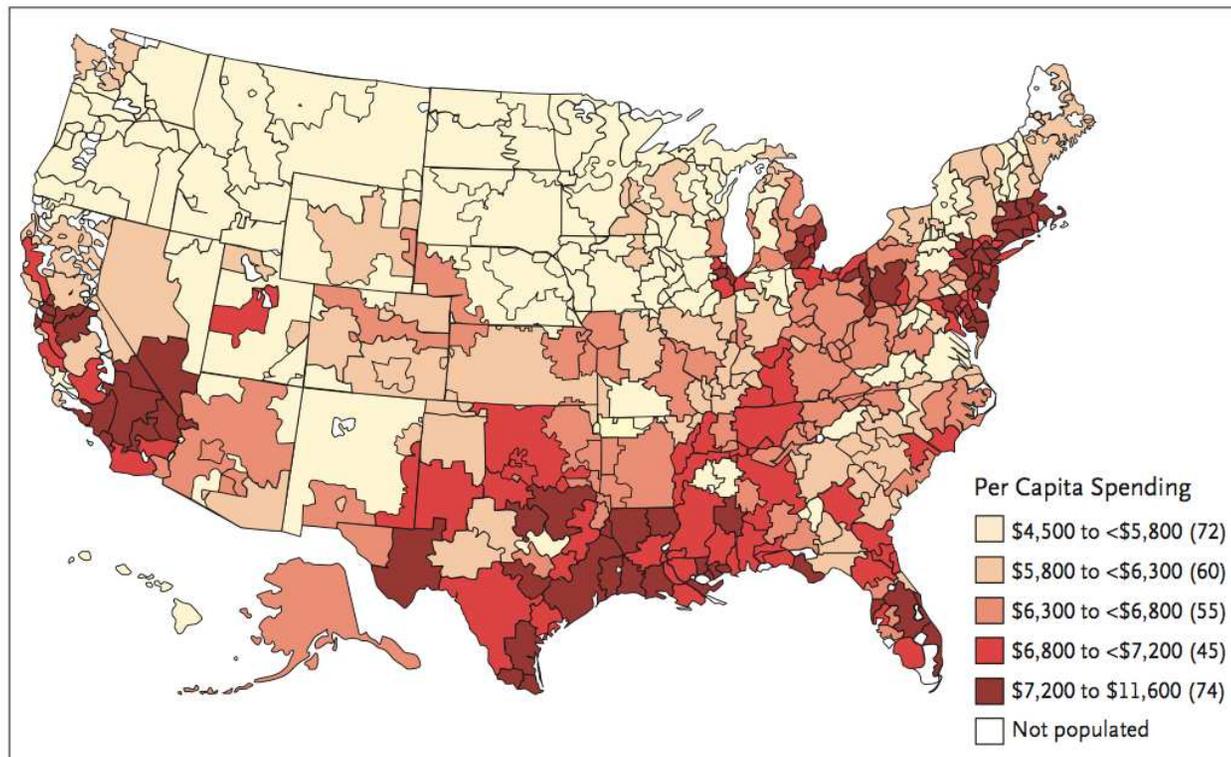
Quality Measurement in the ACO

Will ACOs Work?

Three Fold Variation in Per Capita Spending

PERSPECTIVE

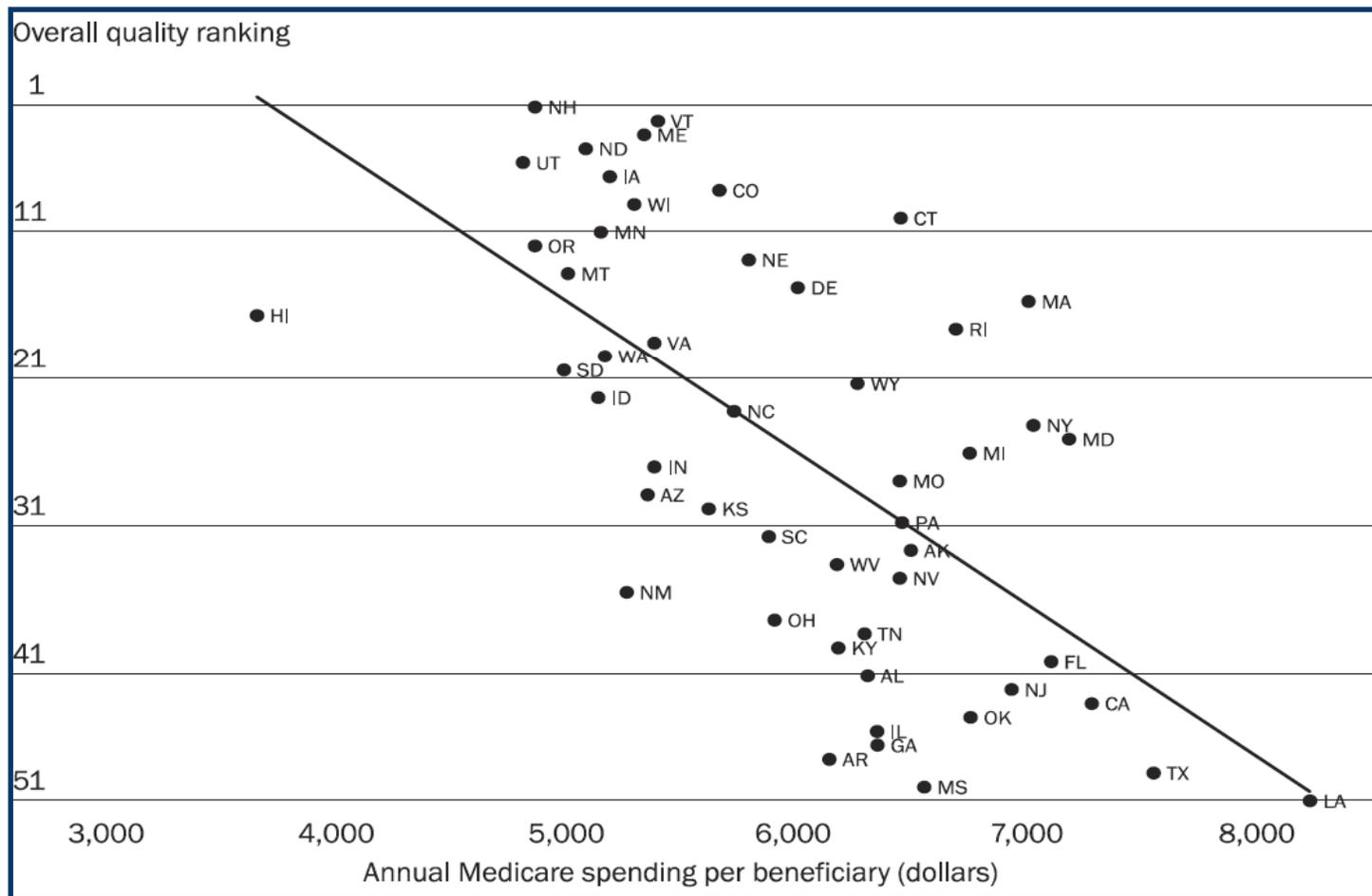
THE CHALLENGE OF RISING HEALTH CARE COSTS — A VIEW FROM THE CONGRESSIONAL BUDGET OFFICE



Medicare Spending per Capita, According to Hospital Referral Region, 2003.

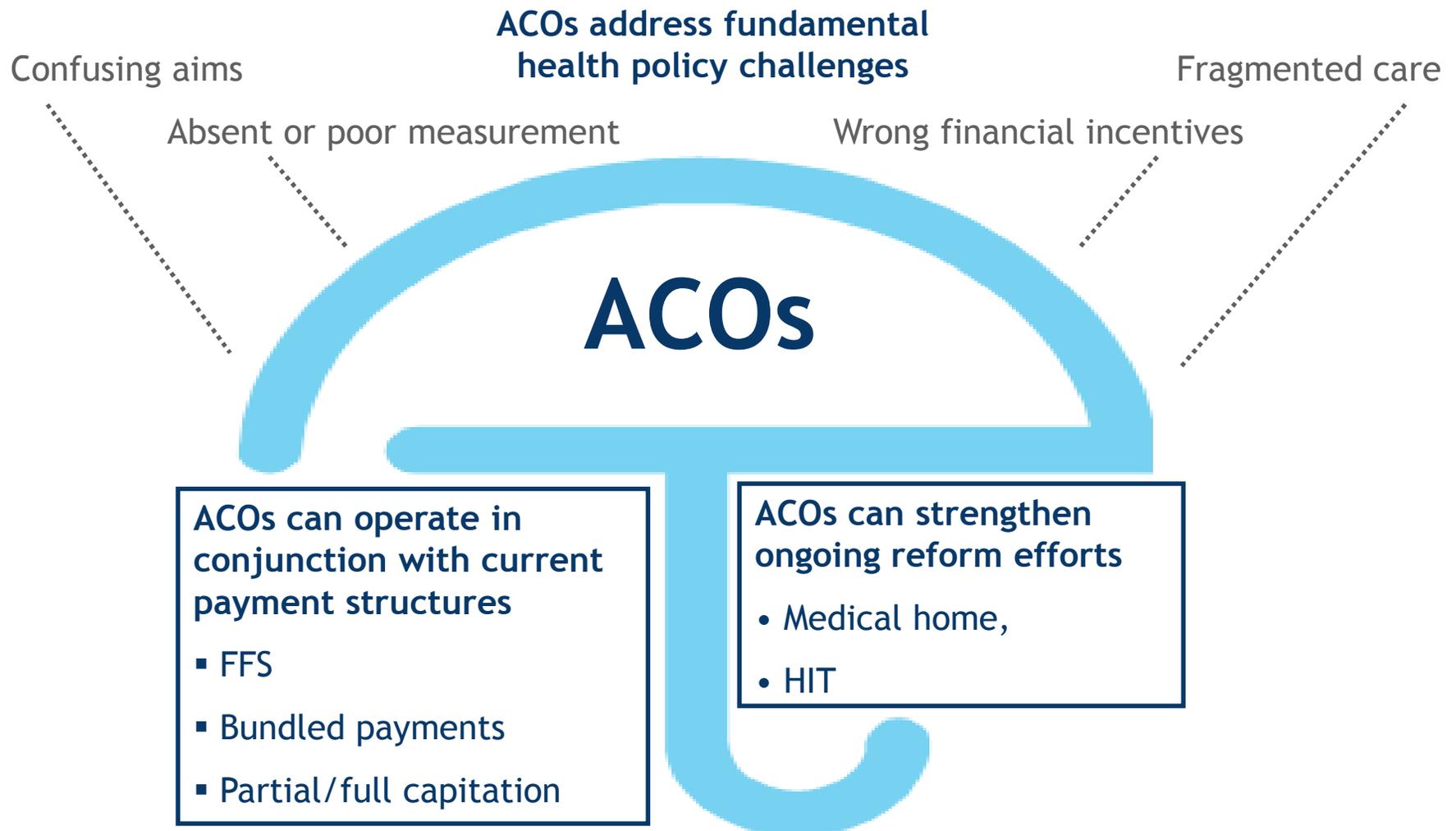
Data are from the Dartmouth Atlas of Health Care. Numbers in parentheses are the numbers of hospital referral regions with that level of per capita spending.

Higher Healthcare Spending is Not Associated with Better Quality



Source: Baicker et al. Health Affairs web exclusives, October 7, 2004

ACO Reform Consistent With Other Reforms



Accountability, “Systemness” & Incentives

Core Principles

Key Design Elements

Clarify aims to emphasize better health, better quality care, lower costs - for patients and communities



- Pay for better value - improved overall health while reducing costs for patients

Better information that engages physicians, supports improvement, and informs consumers



- Provide timely feedback to providers
- Require providers to report on utilization and quality

New model: It’s the system - Establish organizations accountable for aims and capable of redesigning practice and managing capacity



- Establish robust HIT infrastructure
- Implement cost-saving and quality-improving medical interventions
- Evaluate performance at the system level

Realign incentives - both financial and clinical - with aims



- Restructure payment incentives to support accountability for overall quality and costs across care settings

Local accountability is the goal

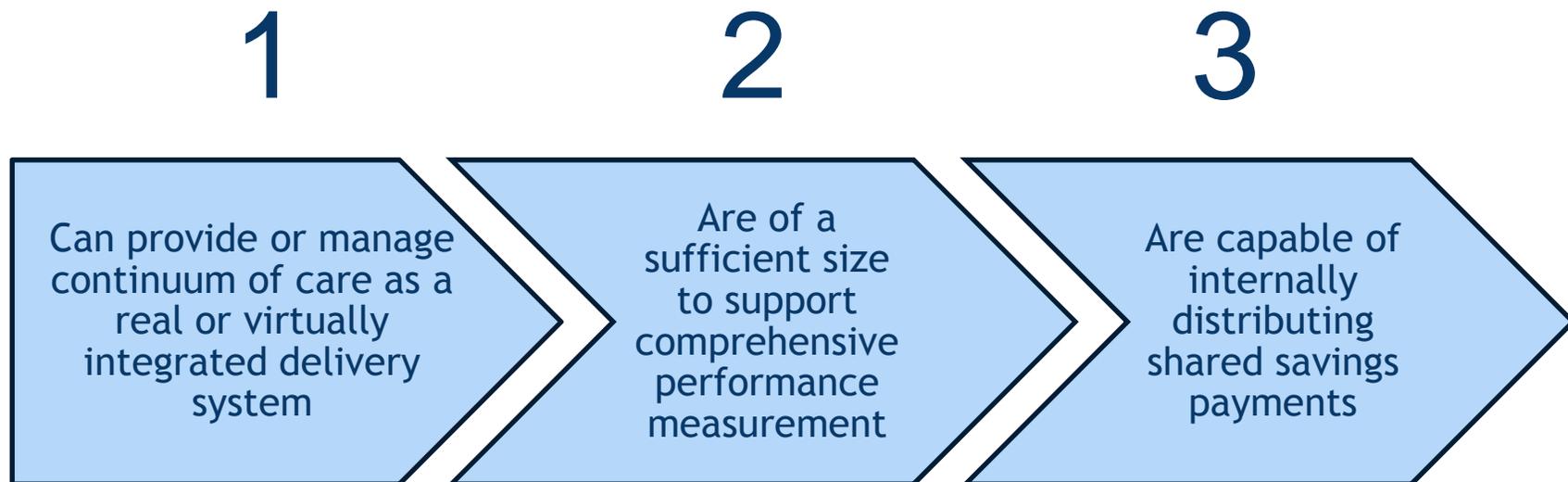
- Currently, there is little accountability for creating unnecessary capacity, practicing “high intensity” medicine, or providing lower quality care.
- Current proposals (bundled payments, chronic disease management, pay-for-performance) do not promote accountability for cost, quality and capacity.

Healthcare is practiced in local markets

Number of <u>Medicare</u> Beneficiaries in Network	Percent of Total Beneficiaries	Number of Local Networks	Patient Loyalty to Local Network
Under 5,000	21.7%	3109	63.6%
5,000 -10,000	26.2%	936	70.8%
10,000 –15,000	20.5%	430	72.9%
15,000 +	31.5%	371	75.6%

Illustrative purposes only using 2004 physician data on hospital use; ACO proposal involves no requirements for hospital-based affiliations. From Elliott S. Fisher, Douglas O. Staiger, Julie P.W. Bynum and Daniel J. Gottlieb, *Creating Accountable Care Organizations: The Extended Hospital Medical Staff*, *Health Affairs* 26(1) 2007:w44-w57.

ACOs Differ But Share a Few, Key Elements



Important Caveats

- ACOs are not gatekeepers
- ACOs do not require changes to benefit structures
- ACOs do not require patient enrollment

Comparison of Different Payment Models

	FFS	Capitation	ACO
Payment Model	Providers are paid per service. Incentive to increase volume.	Providing fixed, “upfront” payments unrelated to volume of services changes incentives, which can raise concerns about “stinting”. Monthly payments can help finance infrastructure and other improvements.	Reduces incentives to increase volume and can work with other reforms that promote coordinated, lower-cost quality care.
Requires patients to enroll with specific providers	No - Patients are not assigned.	Yes -Patients must enroll with designated provider (who receives fixed payment regardless of utilization).	No - Patients can be assigned based on previous care patterns.
Strengthens primary care/fosters care coordination	No - Little incentive to support primary care or care coordination.	Yes - Can provide incentives to support primary care and care coordination efforts.	Yes - Provides incentives to support primary care and care coordination efforts.
Fosters accountability for total per-capita costs and improved quality	Little incentive to manage total per-capita costs or improve quality	Strong accountability for per-capita cost; however, can lack clear link to improved quality.	Accountability for costs in the form of shared savings with eligibility for shared savings linked to meeting quality measures.

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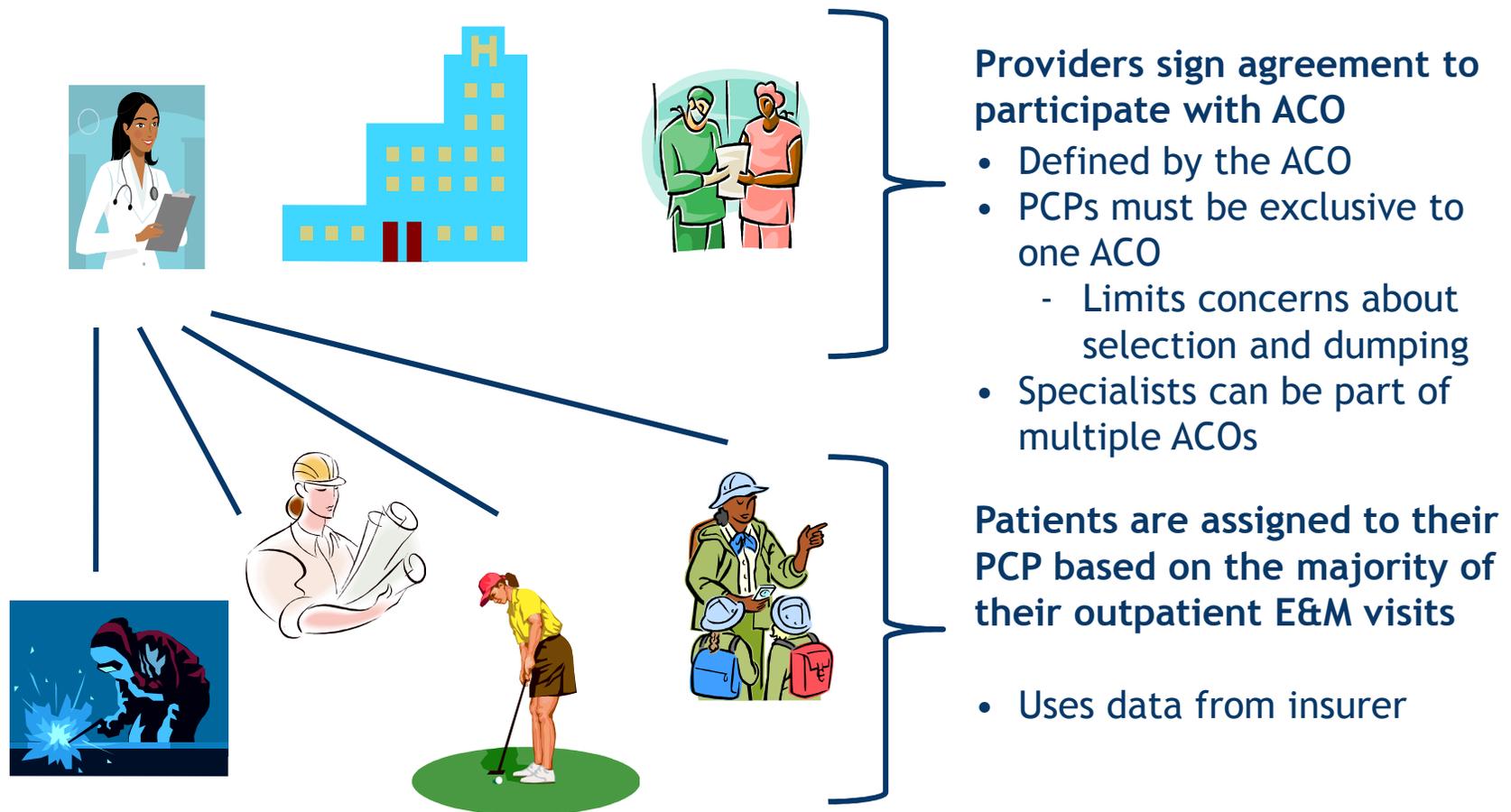
Patient Attribution to the ACO

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Quality Measurement in the ACO

Will ACOs Work?

How are Patients Assigned to the ACO?



Goals of Patient Assignment Method

Unique provider assignment for every patient (no enrollment by patients)

No “lock in” of patients to the ACO (not a gatekeeper model)

Patients are assigned based on where they received their care in the past

Minimize “dumping” of high risk or high cost patients

Important Caveats

- The method is not meant to establish individual provider accountability
- Accountability for assigned patients lies with the ACO, not the individual provider
- Physicians are part of the ACO system of care
- Even providers affiliated with only one ACO can refer patients to non-ACO providers

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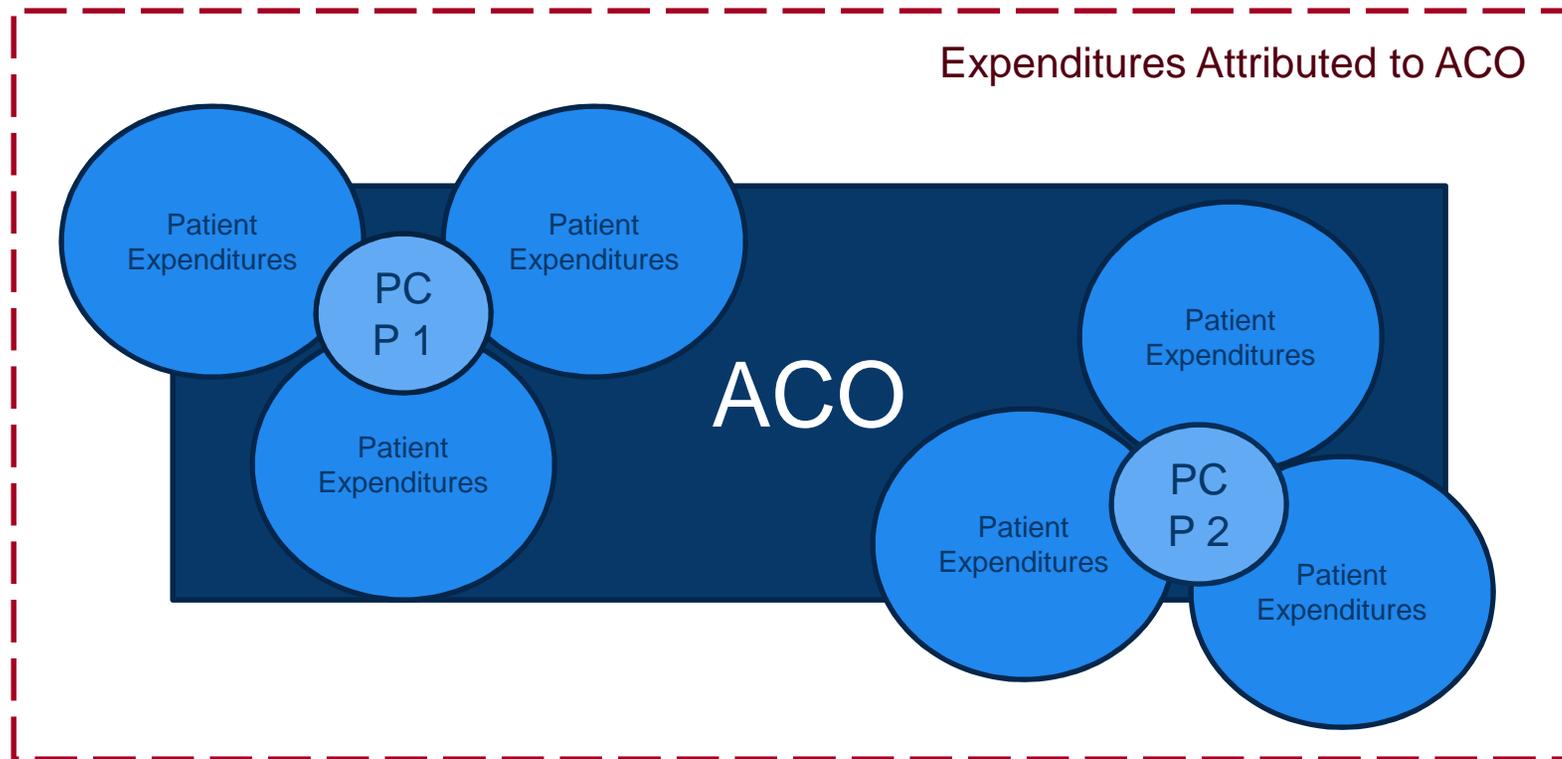
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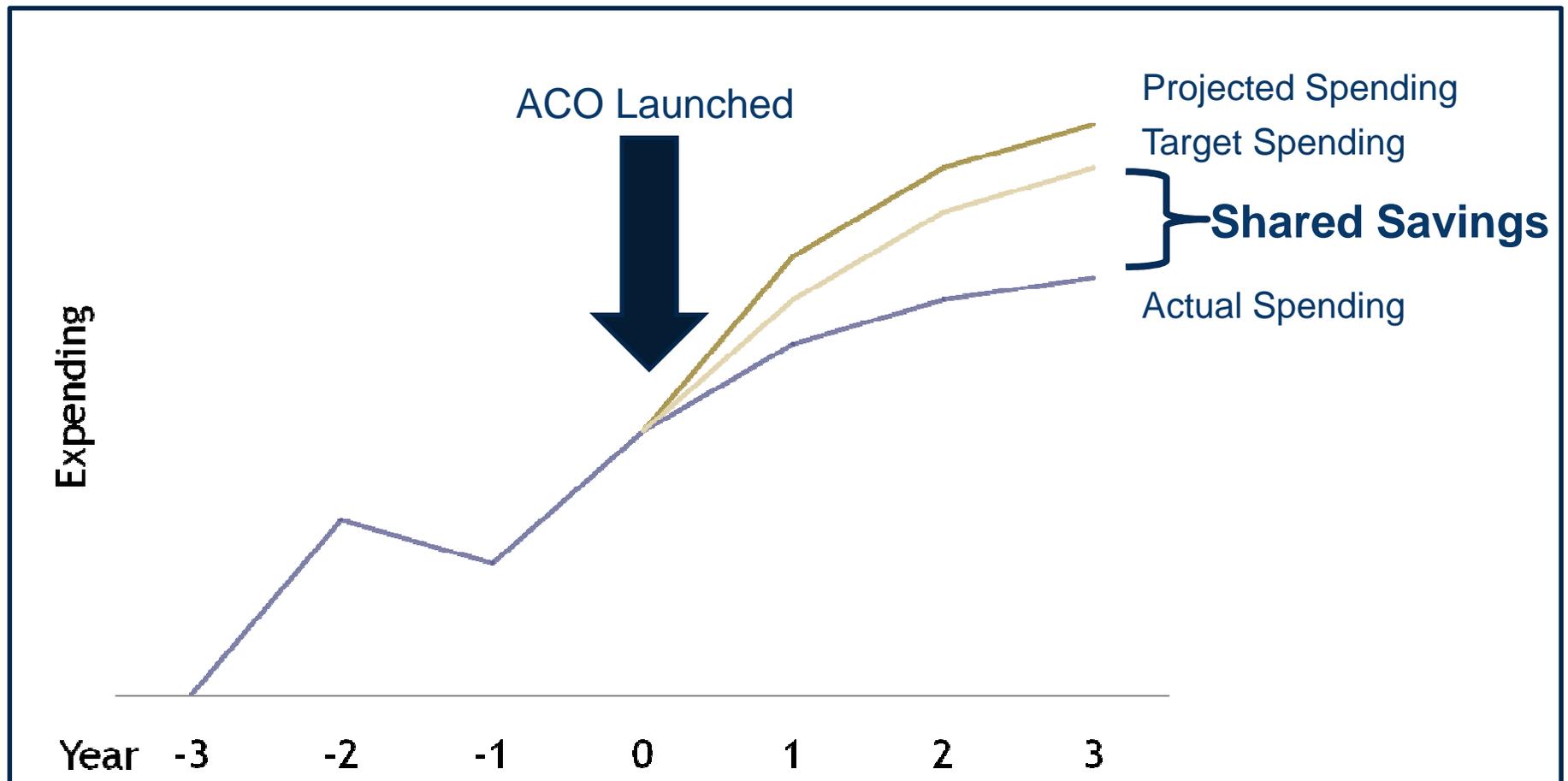
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Will ACOs Work?

ACO is Responsible for all Patient Expenditures



Savings Based on Spending Targets



Performance Payment Framework

ACOs offer a wide range of approaches

Level 1 Asymmetric shared-savings

- Continue operating under current insurance contracts/coverage models (e.g., FFS)
- No risk for losses if spending exceeds targets
- Most incremental approach with least barriers for entry
- Attractive to new entities, risk-adverse providers, or entities with limited organizational capacity, range of covered services, or experience working with other providers

Level 2 Symmetric Model

- Payments can still be tied to current payment system, although ACO could receive revenue from payers and distribute funds to members (depending on ACO contracts)
- At risk for losses if spending exceeds targets
- Increased incentive for providers to decrease costs due to risk of losses
- Attractive to providers with some infrastructure or care coordination capability and demonstrated track record

Level 3 Partial Capitation Model

- ACO receives mix of FFS and prospective fixed payment
- If successful at meeting budget and performance targets, greater financial benefits
- If ACO exceeds budget, more risk means greater financial downside
- Only appropriate for providers with robust infrastructure, demonstrated track record in finances and quality and providing relatively full range of services

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Meaningful Measures; Strategically Deployed

	Current	ACO Model	Impact
Level of Measurement	Individual	ACO (System-Level)	Reduces fragmentation and silos of practice; and, provides an assessment of care because many providers contribute to a patient's care over time.
Types of Measures	Process	Outcomes, Patient Experience, Efficiency	Better data for patients to make choices about providers better data for providers to make changes; Increased accountability for resource use.
Measurement Focus	Individual Provider Accountability for Process	Care Coordination, Shared Decision Making, Capacity Control	Organizational support for managing and improving care; better patient engagement
Provider Focus	Discrete Patient Encounters	Overall health of the population	Shared accountability for the continuum of care.

Beginning, Intermediate, & Advanced

Over time, measures should address multiple priorities, be outcome-oriented, and span the continuum of care

Beginning

- ACOs have access to medical, pharmacy, and laboratory claims from payers (claims-based measures)
- Relatively limited health infrastructure
- Limited to focusing on primary care services (starter set of measures)

Intermediate

- ACOs use specific clinical data (e.g., electronic laboratory results) and limited survey data
- More sophisticated HIT infrastructure in place
- Greater focus on full spectrum of care

Advanced

- ACOs use more complete clinical data (e.g., electronic records, registries) and robust patient-generated data (e.g., Health Risk Appraisals, functional status)
- Well-established and robust HIT infrastructure
- Focus on full spectrum of care and health system priorities

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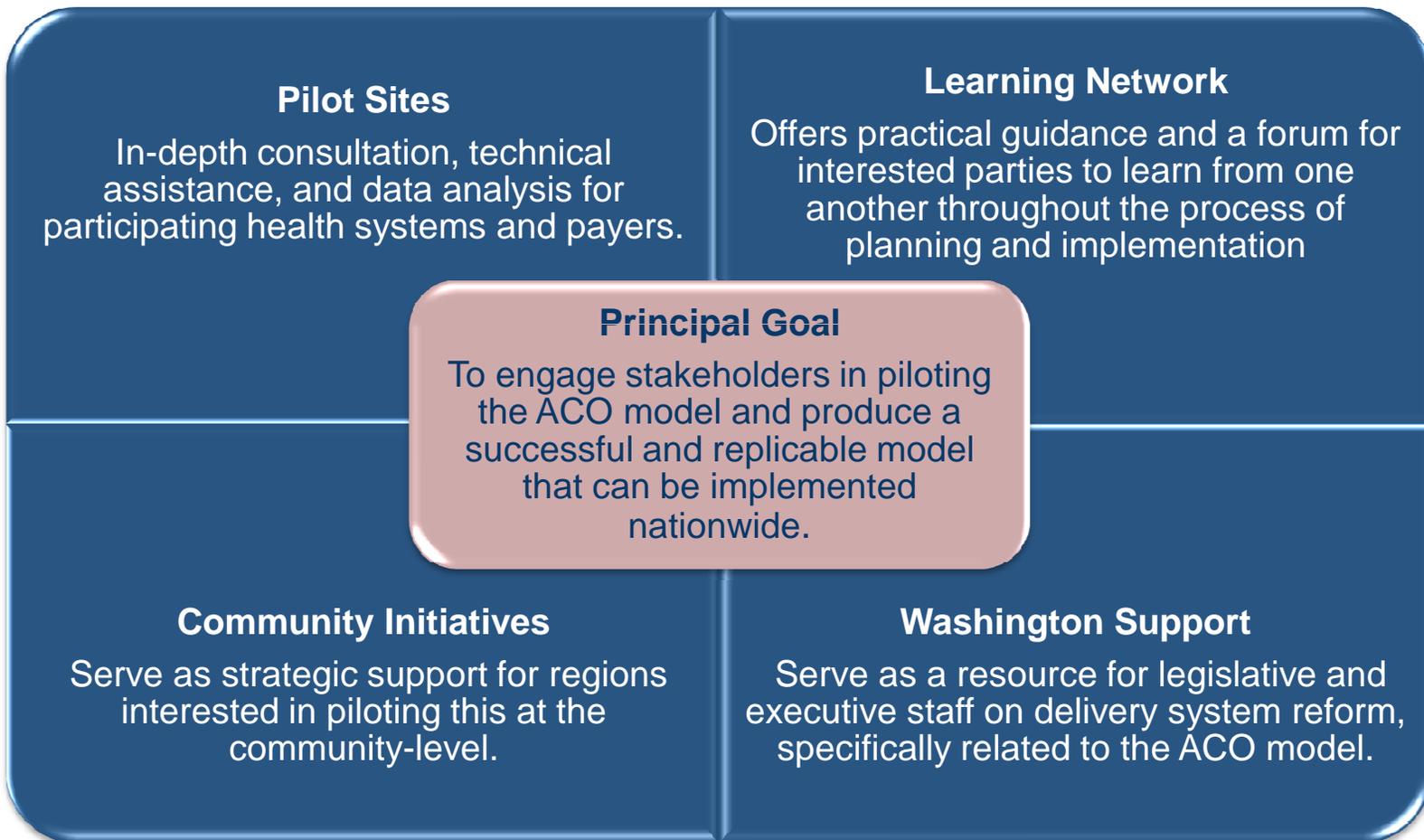
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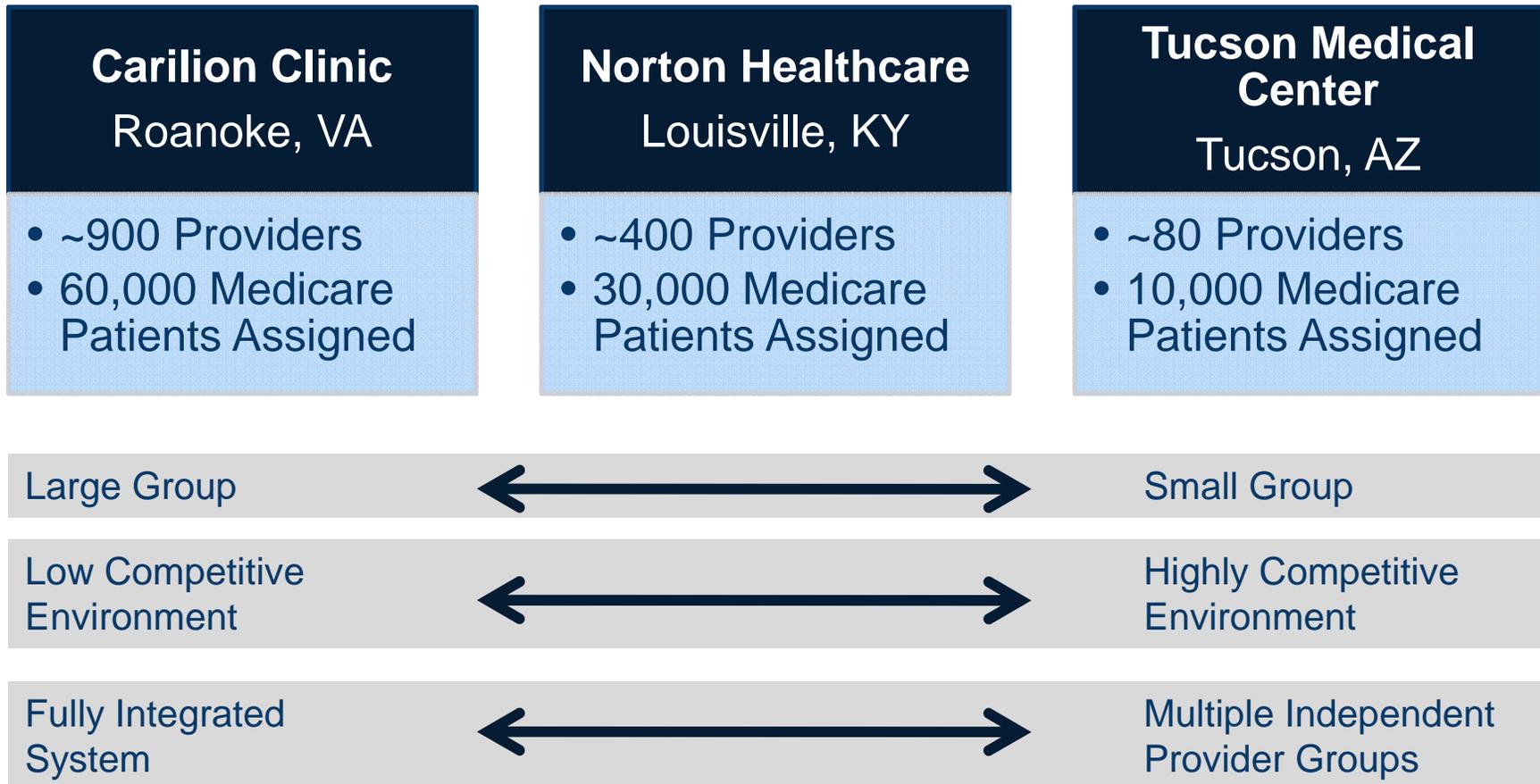
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Brookings-Dartmouth ACO Collaborative



ACO Pilot Sites



Private-Sector ACO Examples: Brookings-Dartmouth Pilot Sites

Monarch HealthCare

Based in Irvine, CA

- Medical Group & IPA
- >800 PCPs
- >2,500 contracted, independent physicians
- ACO will cover Orange County

HealthCare Partners

Based in Torrance, CA

- Medical Group & IPA
- >1,200 employed and affiliated PCPs
- >3,000 employed and contracted specialists
- ACO will cover LA County

Large, highly integrated provider systems operating in highly competitive environment

Medicare Physician Group Practice (PGP) Demonstration Program

- The PGP Demo was legislatively mandated in 2000 as a five-year shared savings/quality improvement demonstration with Medicare
 - **Billings Clinic**; Billings, MT
 - **Dartmouth-Hitchcock Clinic**; Bedford, NH
 - **The Everett Clinic**; Everett, WA
 - **Forsyth Medical Group**; Winston-Salem, NC
 - **Geisinger Health System**; Danville, PA
 - **Marshfield Clinic**; Marshfield, WI
 - **Middlesex Health System**; Middletown, CT
 - **Park Nicollet Health Services**; St. Louis Park, MN
 - **St. John's Health System**; Springfield, MO
 - **University of Michigan Faculty Group Practice**; Ann Arbor, MI

PGP Demonstration Results

- **Year 1**
 - All demos improved clinical management of diabetes; two demos achieved benchmark performance on all 10 diabetes measures
 - Two demos shared in savings (\$7.3 M in payments)
- **Year 2**
 - All 10 demos continued to improve quality scores
 - Four demos shared in savings (\$13.8 M in payments)
- **Year 3**
 - All 10 demos continued to improve quality scores
 - Years 1-3: Average of 10% on diabetes, 11% on CHF, 6% on CAD, 10% on cancer screening, 1% on hypertension
 - Five demos shared in savings (\$25.3M) for achieving 2% per year reductions in spending growth below “control” populations

Medicare “646” Demo: Indianapolis

- The Indiana Health Information Exchange (IHIE), through its Quality Health First (QHF) Program, is a community-wide quality measurement and P4P health information exchange made up of a coalition of physician practices, hospitals, employers, private and public payers, and public health officials
- Multi-payer program includes several components:
 - A comparative performance reporting and tracking system that provides participating physicians with information on the extent to which the care complies with evidence-based practice guidelines
 - A pay-for-performance incentive system that uses information on adherence to treatment guidelines and practice efficiency to distribute savings that are achieved through better care management
- Demonstration waiver authority has added Medicare to the list of participating private and public payers and will allow the IHIE to qualify for a portion of Medicare savings if spending reductions are achieved

Medicare “646” Demo: North Carolina

- The North Carolina Community Care Networks (NC-CCN) is a non-profit organization made up of regional health care networks of community physicians, hospitals, health departments, and other community organizations
- Under the MHCQ demonstration, NC-CCN will test the impact that a physician-directed care management approach will have on care quality and efficiency:
 - Enhanced provider fees for medical homes and use of technology to support care coordination and evidence-based practice
 - Regional physician pay-for-performance program supported by a common set of quality measures
- Demonstration waiver authority expands the program population to the dual eligible and general Medicare FFS population and will provide NC-CCN with the opportunity to qualify for a portion of Medicare savings if spending reductions are achieved

Key Challenges for ACOs

- Will “critical mass” of providers join?
 - Enough assigned patients?
- Will payers agree to participate?
 - Will payers support Level I ACOs, or only deal with existing, integrated systems ready for Level II or III?
- Adequate financing for ACO start-up costs?
 - Infrastructure, IT, analysis, limiting ER use, etc.?
- Adequacy of performance measures, patient assignment algorithm, and budgeting methodology?
 - “Good enough” to get started? How to improve?
- Can ACOs change patient behavior & provider culture?
 - No enrollment, no “lock-in”, no change in benefits?
 - Modest financial incentives, at least in Level I?
- Potential to increase provider concentration and power?

Why ACOs Might Succeed (Over Time)

- Broad, flexible system built on essential core principles
 - Lots of local variation possible within ACO concept
- 3 ACO Levels permit tailoring to different circumstances
 - Broadly applicable throughout the country, with “Training Wheels” for newly formed Level I ACOs
 - Level II offers more reward/more risk (but still limited)
 - Partial Capitation for highly sophisticated entities, extending their model to FFS Medicare and PPOs
- Pathway to fundamentally shift incentives from FFS revenue centers to population health & accountable care
- Opportunity to change clinical and business environment
 - Timely data and analysis
 - Working collaboratively as part of a system of care

Why would providers participate?

- Improved professional working environment
- Realization that at some point volume and intensity will not be able to be increased further
- Understanding that the care currently being delivered is not in the best interest of the patient
- Knowledge of continued reform attempts by all healthcare stakeholders to improve quality and bend the cost curve

How do ACOs reduce expenditures?

Through systematic efforts to improve quality and reduce costs across the organization:

- Using appropriate workforce (increased use of NPs)
- Improved care coordination
- Reduced waste (i.e. duplicate testing)
- Internal process improvement
- Informed patient choices
- Chronic disease management
- Point of care reminders and best-practices
- Actionable, timely data
- Choices about capacity

ACOs in Health Care Reform Law

- **Beyond Pilots**
 - Wide range of provider groups meeting certain criteria can implement an ACO outside of traditional CMS demonstration process through shared savings program
- **Payment Models**
 - Legislation supports a broader range of Medicare ACO payment models than those in current Medicare shared savings demonstrations
 - One-sided and two-side/symmetric shared savings models
 - Range of “partial capitation” models can be established to replace a portion of fee-for-service payments
- **New evaluation methods**
 - New law authorizes pre-post budget projection approach that uses actuarial methods based on historical spending and utilization data to develop quantitative target to track ACO performance

ACOs in Health Care Reform Law

- Medicare shared savings program starting January 1st, 2012 (Section 3022)
 - Qualifying Medicare ACO requirements:
 - Willingness to be accountable for quality, cost, and overall care of Medicare fee-for-service beneficiaries for a minimum of 3 years
 - Have a formal legal structure to receive and distribute shared savings
 - Have at least 5,000 assigned beneficiaries with sufficient number of primary care ACO professionals
 - Report on quality, cost, and care coordination measures and meet patient-centeredness criteria set forth the Secretary
- Center for Medicare and Medicaid Innovation (CMI) to be created in CMS to test payment and delivery models by January 1st, 2011 (Section 3021)
 - \$10 billion authorized for FY2011 to FY2019