Implementing Accountable Care Organizations

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National Accountable Care Organization Congress
October 26, 2010
Today’s talk

• Performance = capabilities + incentives

• Why bother to create an ACO?

• Key factors to watch
What is the goal for an ACO?
population-based care

• Know who your patients are
  – for preventive care
  – by type of chronic illness
• Stratify the patients by risk
• Higher risk patients get more attention
• Care goes on BETWEEN visits, not just during visits
• Help patients learn to manage their own illness
• Measure and improve the organization’s performance
What is needed to reach this goal?

Performance = capabilities + incentives
Capabilities

• leadership with the time, skills, and support to implement organized processes
• clinical information technology
• organized care management processes to improve the health of the population of patients for which the organization is responsible
• physician and staff culture that understands and supports the organized process view of quality
• sufficient size to support meaningful performance measurement
• capable of prospectively planning budget and resource needs
Where will physician leaders come from?

- physician leaders need time, skills, and support from the rank-and-file
- hospitals and large medical groups can support physician leaders
- IPAs tend to underinvest in support
Organized Care Management Processes

- During and between outpatient visits
- Within the hospital
- Transfers
  - outpatient → hospital
  - physician → physician
Changing an organization’s culture: two views of quality

- individual physician view of quality

- organized process view of quality
Individual Physician View of Quality

- quality is what I do:
  - for whatever patients happen to show up
  - while the patient is in front of me

- this view is necessary, but not sufficient
Organized Process View of Quality

• quality is also what an organization does:
  – for the population of patients for which it is responsible
  – using organized care management processes

• should complement the individual physician view

• are you a high quality physician if your organization does not use organized processes to improve care?
Incentives

• Are shared savings enough?
Multiple initiatives within the ACO model:

$800M (Target Expenditures)
- $525M (Traditional Fee for Service Payments)
- $115M (Bundled Payments for Specific Conditions)
- $150M (PMPM Payments for Medical Home)

$10M (Available Shared Savings)

(80/20 agreed upon split)

$8M to the Providers

$2M to the Payers
Is the $8 million a strong incentive?

• What is the cost of creating/maintaining the ACO?

• How much profit was lost by not providing the $10 million of services that created the savings?
Calculating the business case

• Business case for forming an ACO?
• $8 million in shared savings
  - net revenue lost (fewer admissions, procedures . . )
  - cost of creating/maintaining the ACO
  = profit or loss from the ACO

(but there may be other reasons for forming an ACO)
Generating savings
(italics ⇒ loss of income to providers)

• reduce admissions and readmissions
• reduce unnecessary procedures and referrals
• reduce waste (e.g. duplicate testing)
• provide care via least highly paid qualified providers
Generating savings without reducing provider income

- ↑ generic drug use and ↓ inappropriate prescribing
- ↑ operational/care delivery efficiency
- ↓ supply costs (e.g. orthopedic devices)
- ↓ fixed costs/capacity
There should be bonuses for quality and patient experience

• the right thing to do
• if shared savings not enough, may be necessary to add bonuses for quality and patient experience to create a business case for creating ACOs
• funds for bonuses would have to come from elsewhere in the system
  – e.g. slower increase in payment rates for all providers (ACO and non-ACO)
Things to watch (networks)

• can “virtual organizations” (IPAs, PHOs) compete as ACOs with:
  – multispecialty medical groups
  – hospitals that employ physicians?

• if not, will this be the end of small private practice?
Things to watch (hospitals)

• can IPAs or multispecialty groups create high-functioning ACOs without a hospital as part of the ACO?

• will ACOs accelerate the rapid movement toward physicians becoming employed by hospitals?
  – if so, what will be the consequences?
Things to watch (health plans)

• will private payers join public payers in providing incentives for ACOs?
• if not, can an organization succeed in trying to simultaneously increase and decrease the services provided?
• how will the FTC and DOJ deal with anti-trust issues and ACOs?
Things to watch (capabilities)

• even if the incentives are perfect, it takes time to develop leadership, organized care management processes, and a culture of population-based care
• will organizations have enough time to develop these things before they - and/or the ACO concept - fail?
• will rank-and-file physicians support changes
  – knowing that a demonstration project may end in 3 years?
  – when they have one foot in each boat?
More things to watch

• will the CMS Center for Innovation devise more promising ACO demonstrations?

• how stringent will the NCQA guidelines for ACO certification be? will NCQA certification be important?