ACOs: a failed experiment or the future of healthcare?

The Hon. Tevi D. Troy, PhD
Former Deputy Secretary, U.S. Department Of Health And Human Services
Coping with a Challenging and Uncertain Regulatory Environment

- Health care faces significant policy challenges.

- Health care environment rife with regulatory uncertainty.

- Post-elections/Supreme Court/mandate delay/Shutdown fight, regulatory landscape will determine the disposition of the ACA.
OBAMA ADMINISTRATION’S TOP ISSUES

- Economic Recovery
- Energy & Environment
- Healthcare Reform
- Foreign Policy & Defense
- Education
- Immigration
- Faith-Based Initiatives
- HIV/AIDS
- Taxes
- Seniors
- Rural
- Technology
- Disabilities
- Science
- Oceanic Policy
- Transportation
- Veterans
- Women
- Child Advocacy
- Service
- Arts
- Urban Policy
- Ethics
- Civil Rights
- Poverty
- Social Security
- Science
OBAMA ADMINISTRATION’S TOP ISSUES: Healthcare Reform

• Increasing costs
  • 1960: healthcare 5% of GDP
  • 2011: healthcare 17.9% of GDP - $2.7 trillion
  • 2021 (projected), $4.8 trillion - 19.6% of GDP
    • Government expected to spend $2.4 trillion (50% of healthcare spending)
US Health Care Costs

- US Average annual cost of health care was $8,233 per capita -- 2.7x Japan’s in 2010
- U.S. households spent 6% of their annual incomes on health costs
- U.S. performs more expensive diagnostic tests, such as MRI’s and CT’s
- On the other hand, the U.S. does not have an excessive number of doctors or hospital beds relative to its population
- Similarly, duration of hospital stays is not above average

2030 Baby Boomer Projections

- In 2030:
  - The over 65 population will be at 72,091,915 (19% of the overall U.S. population) - 40,228,712 million in 2010 (13% of overall U.S. population)
  - Over 21 million will be considered obese
  - Approx. 14 million will be living with diabetes

www.aha.org/content/00-10/070508-boomerreport.pdf
Breakdown of National Health Care Expenditures: 1965-2010

Source: Office of the Actuary of the Center for Medicare and Medicaid Services
Before Reform Became Law…

- 5 different committees
  - 3 House
  - 2 in Senate

Two Houses of Congress
- House Floor
- Senate Floor
- Conference

- In Senate
  - Reconciliation (51 votes) or Regular Order (60)

- Presidential Signature
### Health Reform Implementation Timeline – Health Disparities

**Key:**
- **Coverage**
- **Individual/Group Markets**
- **Quality Improvements**
- **Workforce**

<table>
<thead>
<tr>
<th>Year</th>
<th>Event/Program/Grant</th>
<th>Reference</th>
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<tbody>
<tr>
<td>2010</td>
<td>Pain Care Management Grants (Sec. 4305)</td>
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<td>2011</td>
<td>National Strategy for Quality Improvements in Healthcare (Sec. 3011)</td>
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<td>2012</td>
<td>Programs to Facilitate Shared Decision-Making (Sec. 3506)</td>
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<td>2013</td>
<td>National Healthcare Workforce Commission (sec. 5101)</td>
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<td>2014</td>
<td>Patient-Centered Outcomes Research Institute (Sec. 6301)</td>
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<td>2015</td>
<td>Medicare Advantage Bonus Payments (Sec. 3201)</td>
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<td>2016</td>
<td>Community Transformation Grants (Sec. 4201)</td>
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<td>2017</td>
<td>Multiple Provisions (Secs. 5301, 5302, 5313, 5402, 5403, and 5507)</td>
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<td>2018</td>
<td>Understanding Disparities: Data Collection and Analysis (Sec. 4302)</td>
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<tr>
<td>2019</td>
<td>Medicare DSH Payment Cuts (Sec. 2551)</td>
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</table>

**Additional Grants/Programs:**
- Funding for National Health Service Corps (Sec. 5207)
- Additional Requirements for Non-Profit Tax-Exempt Hospitals (Sec. 4959)
- Preventive Medicine and Public Health Training Grant (Sec. 10501)
- Quality Measure Development (Sec. 3013)
- Education and Outreach Campaign Regarding Preventive Benefits (Sec. 4004)
- Requirement for Uniform Explanation of Coverage Documents, Standardized Definitions, and an Appeals Process (Sec. 1001)
- HiE Special Rules Incentive Payments (Sec. 1311)
- Investment in Historically Black Colleges and Universities and Minority Serving Institutions (Sec. 2104 – Reconciliation Bill)
- Community Health Teams (Sec. 3502)
- Removing Barriers and Improving Access to Wellness for Individuals with Disabilities (Sec. 4203)
# Health Reform Implementation Timeline – Health Disparities

<table>
<thead>
<tr>
<th>Year</th>
<th>Event Description</th>
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<tr>
<td>2010</td>
<td>Nondiscrimination in Health Insurance Exchanges (Sec. 1557)</td>
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<td>Indian Healthcare Improvement (Sec. 10221)</td>
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<td>School-Based Health Centers (Sec. 4101)</td>
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<td>Oral Healthcare Prevention Activities (Sec. 4102)</td>
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<td>Healthcare Workforce Loan Repayment Programs (Sec. 5203)</td>
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<td>Multiple Provisions (Secs. 5102, 5303, 5307, 5401)</td>
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<td>Funding for Childhood Obesity Demonstration Projects (Sec. 4306)</td>
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<td>Improving Women’s Health (Sec. 3509)</td>
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<td>Community-Based Care Transition Teams (Sec. 3026)</td>
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<td>National Diabetes Prevention Program (Sec. 10501)</td>
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<td>Community Health Centers (Sec. 2303 – Reconciliation Bill)</td>
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<td>Breast Cancer Awareness (Sec. 10413)</td>
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<td>2011</td>
<td>State Exchanges Must Require Information to be Submitted in Plain Language (Sec. 1303)</td>
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<td>Increased Funding to the Territories (Sec. 1204 – Reconciliation Bill)</td>
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<td>2012</td>
<td>Medicare DSH Payment Cuts (Sec. 1104, 1203 – Reconciliation Bill)</td>
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**Key:**
- **Coverage**
- **Individual/Group Markets**
- **Quality Improvements**
- **Workforce**
## Analysis of CHT Timeline

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<tr>
<th>Type</th>
<th>Pre-enactment</th>
<th>Upon enactment</th>
<th>6 months post enactment</th>
<th>By Jan 1, 2011</th>
<th>1 year post enactment</th>
<th>1 year post enactment to Jan 31, 2011</th>
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<td>16</td>
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Intense effort to micromanage

- The Affordable Care Act (ACA) has required almost 20,000 pages of regulations, elaborating on the original 2,700 page law.

- Can be very specific. Consider Section 4102 of the ACA, which states: "The secretary shall develop oral healthcare components that shall include tooth-level surveillance."

- Not necessarily welcome: 51% of doctors percent felt that the law would have a negative impact on their relationships with their patients
Goal of ACA: Shared Savings from ACOs

- According to CMS, “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”

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html?redirect=/aco/
Other Takes on ACOs (Humorous)

- I don't know how to define an ACO, but I know it when I see it.
- The three greatest mythical creatures are the abominable snowman, the Loch Ness monster, and ACOs.
- ACO is an HMO on steroids.
- We already tried ACOs, they were called HMOs.
The reality

• ACOs were promoted as a key factor in cutting costs significantly and improving health.
• So far the CBO has not shown any data with more than trivial savings.

Current state of ACO programs

• Pioneer Program
  ▫ 32 Pioneer ACOs
  ▫ 13 out of 32 produced savings
  ▫ 7 that did not generate savings will leave Pioneer program and apply for MSSP
  ▫ 2 Pioneer ACOs had losses, totaling in approximately $4 million

Current state of ACO programs

- Medicare Shared Savings Program (MSSP)
  - 220 participants
  - 3.2 million beneficiaries
  - 20% of ACOs include community health centers, rural health clinics and critical access hospitals that serve low-income and rural communities

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/All-Starts-MSSP-ACO.pdf
&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=1%2C2%2C3%2C4%2C5&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date
Faults with ACOs

- Still based on fee-for-service (FFS)
- Few tools to control utilization
- Performance benchmark issues
- Burden of set up costs
- Lack of beneficiary involvement – don’t know they are participating
- Problematic initial regulation
Still based on fee-for-service (FFS)

- Providers do not get paid for high quality or innovative services
- Still an incentive to “churn” patients
- FFS weakens incentive for providers to work collaboratively
“Get the government out of the business of fixing prices for "fee for service" doctor visits—and give them predetermined payments for a set of services and real financial incentives to change outcomes for the better. Doctors drive care decisions and spending.”

- Former CMS head Tom Scully, WSJ interview

http://online.wsj.com/article/SB10001424052970204720204577128901714576054.html
Few tools to control utilization

- Beneficiaries cannot be forced to stay in-network, ACO is still responsible for utilization
  - Due to lack of knowledge, often times beneficiaries do not know they are going out of the network
- No prior authorization
- Beneficiary cost sharing cannot be modified
“Many physicians are reluctant to assume accountability for patient outcomes since they recognize that much of the outcome is directly under the behavioral control (and thus accountability) of the patient-consumer.”

- Rita E. Numerof, Ph.D., Why Accountable Care Organizations Won’t Deliver Better Health Care – and Market Innovation Will

Performance benchmark issues

- Instead of market competition, ACOs will be competing against themselves.
- Diminishing Returns - ACOs that have large room for improvement will see better savings than already highly integrated groups, eventually all ACOs will struggle to see long term savings.
Burden of start-up costs

- Medicare does not help pay for either Pioneer or MSSP start up costs
- Most physicians are too small to have enough financial capital to build the sophisticated systems needed
- Initial cost of start up is $30 million and up
- Can lead to unfair competitive advantage to large organizations

http://online.wsj.com/article/SB10001424052970204720204577128901714576054.html
• “The ACO actually looks like a terrible business deal for providers. In order to get any shared savings, they will have to spend millions on consulting, systems, care managers and IT staff, give up a dollar in immediately reduced income, and maybe, if they check all the boxes right, get 50 or 60 cents back in 18 months.”

- Jeff Goldsmith, WSJ interview

http://online.wsj.com/article/SB10001424052970204720204577128901714576054.html
Lack of beneficiary involvement

- “Passive enrollment”- beneficiaries do not select their ACO, it is assigned to them depending on the physicians they have seen in the past
- Beneficiaries have no incentive to lower costs and be smart consumers
- There is no accountability to improve health status, behavior, or reduce high-expense utilization
• “Taking the patient-consumer out of the equation undermines any attempt at creating true accountability for health care decisions.”
  
  - Rita E. Numerof, Ph.D., *Why Accountable Care Organizations Won’t Deliver Better Health Care – and Market Innovation Will*

• “The biggest problem with the ACO, however, isn't the faulty business proposition, but the patient's role.”
  
  - Jeff Goldsmith, WSJ interview

http://online.wsj.com/article/SB10001424052970204720204577128901714576054.html
Troublesome initial rule

- Economic disincentives
- Over-directed
- Did not encourage “normal” organizations to form ACOs
Other options

- “3rd Option”
  - Clinically integrated organizations (CIOs)
    - Explicitly physician centric, but can be co-owned/made up of physicians, hospitals, nursing homes, etc
    - Team-based care led by primary care physician
  - Active Beneficiary Selection
    - Sign up during MA open enrollment and choose between traditional Medicare, FFS and CIO; also choose PCP
  - Benefits
    - Cover the standard Medicare Part A & B; D would exist alongside this 3rd option
“3rd option”

- **Premium**
  - Some kind of participation incentive to beneficiaries
- **Beneficiary Alignment**
  - Services from outside CIO will have higher out of pocket costs
Other options

- Capretta Plan
  - ACOs replaced by integrated FFS plans in Medicare
    - Beneficiaries are given the option to choose plans
  - Compete with other similar plans and MA
    - Must provide Medicare with estimated cost-reduction amounts, this translates to reduced premiums
  - Supplemental insurance prohibited from completely covering Medicare’s cost sharing, unless beneficiary enrolled in integrated plan
BPC’s “Medicare Networks”

- Enhanced version of ACOs
- Defined benefits and open access to all Medicare providers
- A few key changes from ACOs
  - Enrollment-based
  - Strong financial incentives to participate
  - Two-sided risk
BPC’s “Medicare Networks”

• Enrollment Based
  ▫ Beneficiaries select their plan instead of being assigned to one

• Strong Financial Incentives to Participate
  ▫ Part B premium rebates, guaranteed at least $60 annual discount for the first 3 years
  ▫ Lower cost sharing to see Medicare Network providers
  ▫ Incentives for providers to move away from FFS
BPC’s “Medicare Networks”

- Two sided risk
  - Medicare Networks each have a spending target
  - If Medicare Network meets quality and patient satisfaction goals, they share in savings
  - Providers also assume risk in absorbing a part of anything spent over the target
Advantages to Alternative Options

• More flexibility for the shared saving entities
• Greater ability to secure the cooperation of participants
• Competition can help hold down costs
Summary

• Still some hope in the area of shared savings
• There is less promise of ACOs by the Affordable Care Act due to heavy regulations
• ACOs would have a better chance if beneficiaries were given more choice . . . And if they were given more tools to control costs
• ACOs are not the short term savior for high health care costs
ACOs: a failed experiment or the future of healthcare?

The Hon. Tevi D. Troy, PhD
Former Deputy Secretary, U.S. Department Of Health And Human Services