The Policy and Political Context Of Accountable Care

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This Presentation at a Glance: Questions

- Is ACO model transitional or long-term?
- California’s coordinated care model: is it a national template, or unique to state and sui generis?
- Will ACO terminology survive?
- What will be future focus of health care transformation?
The Future Of ACO’s
“It turns out that plenty of people hate Obamacare, but love the Affordable Care Act. What they don’t know is that they’re the exact same thing.”
Similarly…

...Which will we prefer and end up with: ACO’s or Accountable Care?
Original “Accountable Care Organization Model”

- Elliott Fisher and colleagues from Dartmouth Medical School
- Based on hospital referral regions and physician referral patterns
- Predicated on fee-for-service payment with quality improvement targets and incentives
- In same “gene pool” as Medicare Physician Group Practice demonstration (DHMC was participant), 2005-2009
- Model has evolved substantially ever since – into Section 3022 plans in ACA, plus CMMI products (Pioneer, etc.) and beyond

Source: Fisher EC et al, “Creating Accountable Care Organizations: The Extended Hospital Medical Staff,” Health Affairs, December 2006, w44-w57
ACO Principles

- Put the patient and family at the center
- Have a memory about patients over time and place
- Attend carefully to handoffs, especially as patients journey from one part of the care system to another.
- Manage resources carefully and respectfully
- Be proactive
- Be data-rich
- Innovate in the service of the Triple Aim: better and better patient care, better population health, and lower cost through improvement.
- Continually invest in the development and pride of its own workforce, including affiliated clinicians.
ACO’s Through A Realist Lens

- “The accountable care organization is a guess.”

- “The ACO model is not a panacea.”

- “Nor are ACO’s the only hope; they are just one program – albeit a highly visible one – in a suite of new forms and environments that the nation will be testing in the next few years.”

Payment and Delivery System Innovation: Improving Value And Affordability

Old Model

- Reward unit cost
- Inadequate focus on care efficiency and patient centeredness
- Payment for unproven services; limited alignment with quality

New Model

- Reward health outcomes and population health
- Lower cost while improving patient experience
- Improve quality, safety and evidence
Performance-based Innovations Under CMS: All Forms of Accountable Care

- Patient Centered Medical homes: e.g., all-payer national pilot; federally qualified health centers; 1 in 2 states in Medicaid
- Comprehensive Primary Care initiative
- Accountable Care Organizations: Medicare Shared Savings Plan, Pioneer, Advance Payment, Comprehensive End-Stage Renal Disease Care Initiative; possibly other condition-specific programs to come
- State Demonstration Projects for Dual Eligibles
- Medicare Hospital Value-based Purchasing
- Bundled Payments for Care Initiatives
- State Innovation Model Grants
- Partnership for Patients/program to reduce avoidable readmissions
More to Come: SGR Replacement

- Bipartisan House/Senate Proposed Replacement for Sustained Growth Rate formula in Medicare Part B

- Permanently repeal the SGR update mechanism, reform the fee-for-service payment system through greater focus on value over volume, and encourage participation in alternative payment models (APM).

- Current Part B payment levels frozen for ten years; individual physicians and other health care professionals could earn performance-based incentive payments through a compulsory budget-neutral program.

**More to Come: SGR Replacement**

- Under a new “Value Based Payment Program,” separate quality ratings consolidated into one – e.g., Physician Quality Reporting System, Meaningful Use, physician value-based modifier.

- Penalties in these programs turned into incentives.

- Professionals who receive “significant portion” of revenue” from APM(s) that involves *two-sided financial risk and a quality measurement component* ("advanced APM") exempted from performance-based incentive program, and instead receive bonus payment starting in 2016.

- Beyond 2023, professionals in advanced APM(s) would receive annual updates of two percent; all others would receive annual updates of one percent.
Key Elements of Transforming Care

Transformation of Health Care at the Front Line

- At least six components
  - Quality measurement
  - Aligned payment incentives
  - Comparative effectiveness and evidence available
  - Health information technology
  - Quality improvement collaboratives and learning networks
  - Training of clinicians and multi-disciplinary teams

Source: P.H. Conway and Clancy C. Transformation of Health Care at the Front Line. JAMA 2009 Feb 18; 301(7): 763-5
What exactly are the distinguishable features of ACO’s?
Medicare ACO’s

4 million Medicare beneficiaries having care coordinated by 220 SSP and 32 Pioneers ACOs
(Geographic Distribution of ACO Population)
Pioneer ACO Results, 7.16.13

- Illustrate successes and challenges
- 13 of 32 plans saved money ($87 million gross)
- Shared savings = $33 million for Medicare
- Two plans initially thought they lost money ($4 million); turned out one of those (Atrius) did not upon recalculation
- Per beneficiary costs grew 0.3 percent versus 0.8 percent for matched beneficiaries
- All boosted the quality of care over traditional FFS Medicare and earned quality incentive payments
- Some plans did not share savings; 9 left program; 7 of the 9 switched to the Medicare Shared Savings ACO’s, which aren’t expected to move toward capitation
- The 2 other organizations still have non-Medicare ACO contracts
- Tentative conclusions: Change is hard, but possible; not all will be able to move quickly toward capitation
Ongoing Concerns About Medicare ACO’s

- Extent of savings for Medicare?
- Consolidation and collaboration to increase provider market power and raise rates to private payers?
- Risk selection of healthier patients?
- Effectiveness of CMS plans to risk adjust beneficiaries in ACO’s with CMS Hierarchical Category Coding mechanism developed for Part C plans?
Ongoing Concerns About Medicare ACO’s

- To what degree is culture, not payment methodologies, going to be the “secret sauce” of some systems’ successes?

- Will data from CMS flow faster to enable ACOs to do better job preemptively shaping care?

- Financial viability of model: ThedaCare, a Pioneer participant, saw revenue decline of 0.7 percent in first six months of 2013 due to a 10% reduction in FFS Medicare admissions and movement of many beneficiaries to Medicare Advantage plans (see Toussaint J et al, JAMA, 310: 13, October 2, 2013)

- Less revenue earned on patients outside of Medicare = no chance to “share savings” unless all payers move to value-based models
ACOs in Private Sector – e.g., Blue Shield of California

- Launched pilot ACO with Dignity Health (formerly Catholic Health Care West) and Hill Physicians in January 2010 for 41,000 CalPERS employees and dependents

- Global budget; shared upside and downside risk

- Tactics included eliminating unnecessary care, such as excessive bariatric surgery; coordinating processes such as discharge planning; reducing variation in practices and resources; reducing pharmacy costs

- 2010-11 combined results: $37 million in savings to CalPERS; compounded annual growth rate for per member per month costs was ~ 3% vs. ~7% for everyone else
Alternative Quality Contract, Blue Cross Blue Shield of Massachusetts

- Provider organizations bear financial risk for spending on commercial enrollees in excess of a global budget and share savings below budget

- Receive bonuses for meeting performance targets on quality measures

- Incentives similar to two-sided payment arrangements in Medicare ACO’s

- Associated with lower spending and improved quality of care; savings increased in second year

- Also associated with lower spending for Medicare enrollees not covered by contract, but not with consistently improved quality

Medicare Advantage

- Nearly 1 in 3 Medicare enrollees now in Medicare Advantage (Part C); 5% growth projected in 2014 (faster than overall enrollment growth)

- Steady but dramatic increase in the number of plan beneficiaries who are in 4-Star and 5-Star plans – 55 percent in 2014 (quality incentives)

- CMS also pays Medicare Advantage plans substantially less than before ACA; average plan payments were 114 percent of Medicare fee-for-service overall and now close to 103 percent and headed to parity

- Per capita costs in Part C is essentially flat
ACO’s in Medicaid

- Keystone First, a Blue Cross Medicaid plan in Pennsylvania with 303,000 members, and Jefferson Health System (6 acute care hospitals, 2 rehab hospitals, physicians)

- Multiyear shared savings agreement

- Agreed-upon quality metrics on preventable readmissions, low-acuity emergency department visits, neonatal intensive care length-of-stay, achieving HEDIS measures in obstetrics and primary care
“We’re Not Sure Where We’re Going But We’re Starting Somewhere”
Organizations (WNSWWGBWSSO’s)

3 Philadelphia-area health systems: Abington Health, Aria Health and Einstein Health Network – teaming to form an LLC

- “Work together initially to manage health care benefit plans of the systems’ employees and their families – approximately 30,000 people (self-insured)

- Longer term, “establish a platform to improve care delivery throughout the community and improve the health of populations through highly coordinated and efficient care.”

- Source: Joint news release, July 16, 2013
ACO’s Version 2.0

- CMS/CMMI beginning to discuss

- Key takeaways

- Measures of performance have to evolve and transition from process to patient-centered health outcomes

- Beneficiaries need active “buy-in” – incentives to stay in systems and help co-produce health

- Population health focus needs to expand

- Payment should move toward capitation/shared savings but will need to have different models for some time
The Thinking at CMS/CMMI

The Future of Quality Measurement for Improvement and Accountability

- Meaningful quality measures increasingly need to transition away from setting-specific, narrow snapshots
- Reorient and align measures around patient-centered outcomes that span across settings
- Measures based on patient-centered episodes of care
- Capture measurement at 3 main levels (i.e., individual clinician, group/facility, population/community)
- Why do we measure?
  - Improvement

Source: Conway PH, Mostashari F, Clancy C. The Future of Quality Measurement for Improvement and Accountability. JAMA 2013 June 5; Vol 309, No. 21 2215 - 2216
ACO’s Version 2.0

Opportunities and Challenges of a Lifelong Health System

- Goal of system to optimize health outcomes and lower costs over much longer time horizons
- Payers, including Medicare and Medicaid, increasingly responsible for care for longer periods of time
- Health trajectories modifiable and compounded over time
- Importance of early years of life

Source: Halfon N, Conway PH. The Opportunities and Challenges of a Lifelong Health System. NEJM 2013 Apr 25; 368, 17: 1569-1571
ACO’s Version 2.0

Financial Instruments and models that might incentivize lifelong health management

- Horizontally integrated health, education, and social services that promote health in all policies, places, and daily activities
- Consumer incentives (value-based insurance design)
- “Warranties” on specific services
- Bundled payment for suite of services over longer period
- Measuring health outcomes and rewarding plans for improvement in health over time
- Community health investments
- ACOs could evolve toward community accountable health systems that have a greater stake in long-term population health outcomes
“RECOMMENDATION 3: To improve value, CMS should continue to test payment reforms that incentivize the clinical and financial integration of health care delivery systems and thereby encourage their

(1) coordination of care among individual providers,

(2) real-time sharing of data and tracking of service use and health outcomes,

(3) receipt and distribution of provider payments, and

(4) assumption of some or all of the risk of managing the care continuum for their populations.

Further, CMS should pilot programs that allow beneficiaries to share in the savings due to higher-value care.”
Medicare Reform Proposals: E.g., Bipartisan Policy Center, Engelberg Center

- Restructure Medicare/health care to better link payment for value to better coordinated care delivery

- Medicare Networks/Medicare Coordinated Care Organizations: Improved versions of Accountable Care Organizations

- Competitive bidding in Medicare Advantage

- Fallback spending limit that would hold per-beneficiary annual growth in Medicare spending to rate of growth of economy (GDP) + .5 percent
Continuing Challenges Ahead


Cost curve still not bent enough
Some Best-Guess Conclusions

- ACO models in public and private sector will continue to evolve and take multiple forms

- “Accountable care” will become dominant over long haul

- Quality will improve, cost growth will moderate and some savings will be had (assuming measurement difficulties)

- Ongoing system transformation will push toward narrower accountable care networks focused on population health and enrollee incentives to participate
What we will really need...

...the retrospectoscope!
The End