The Policy and Political Context Of Accountable Care

Presentation by
Susan Dentzer
Senior Policy Adviser
Robert Wood Johnson Foundation

2013 Accountable Care Congress
November 4, 2013

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

The Way We Were…October 1, 2013

- **"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."**

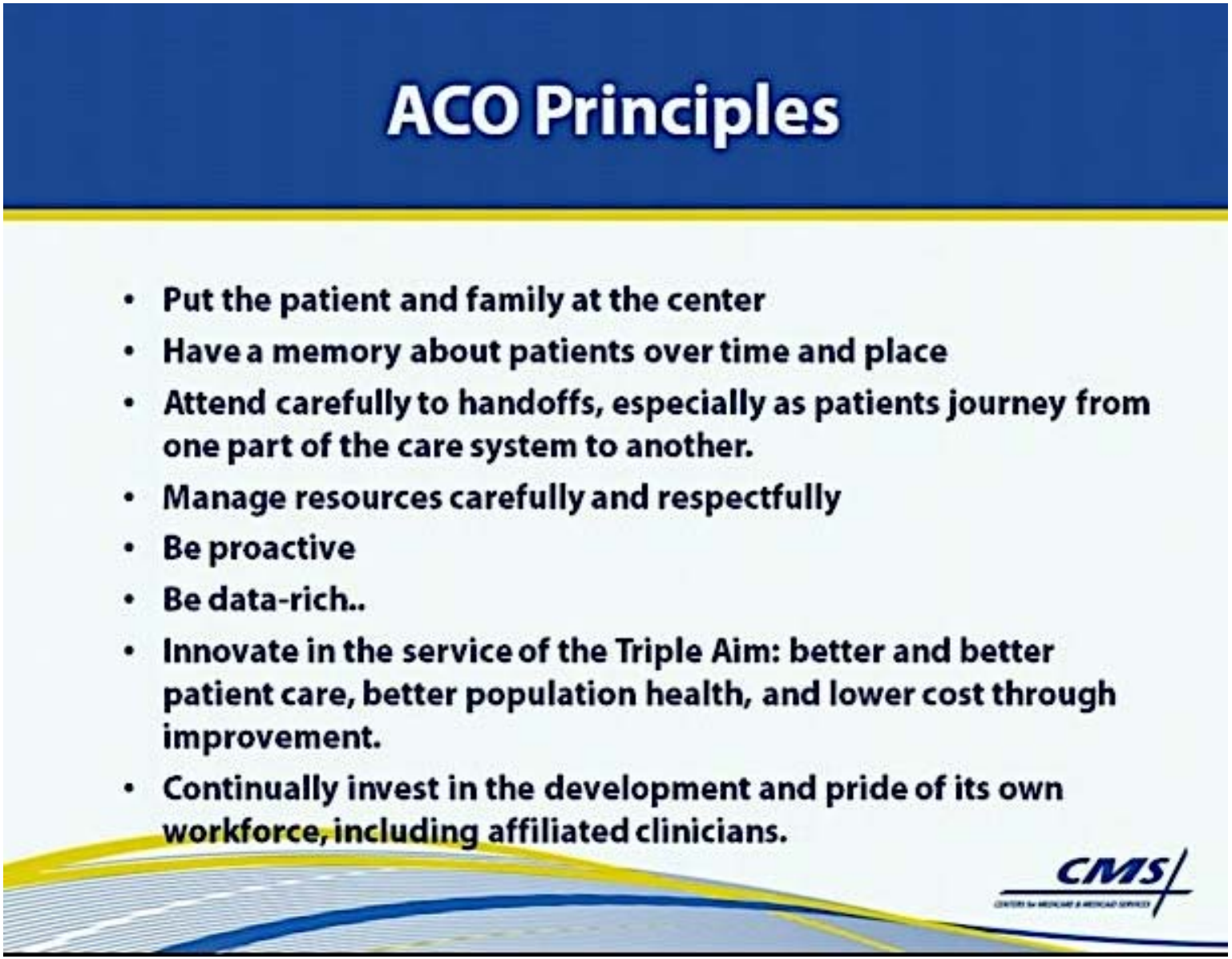
Similarly….

…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

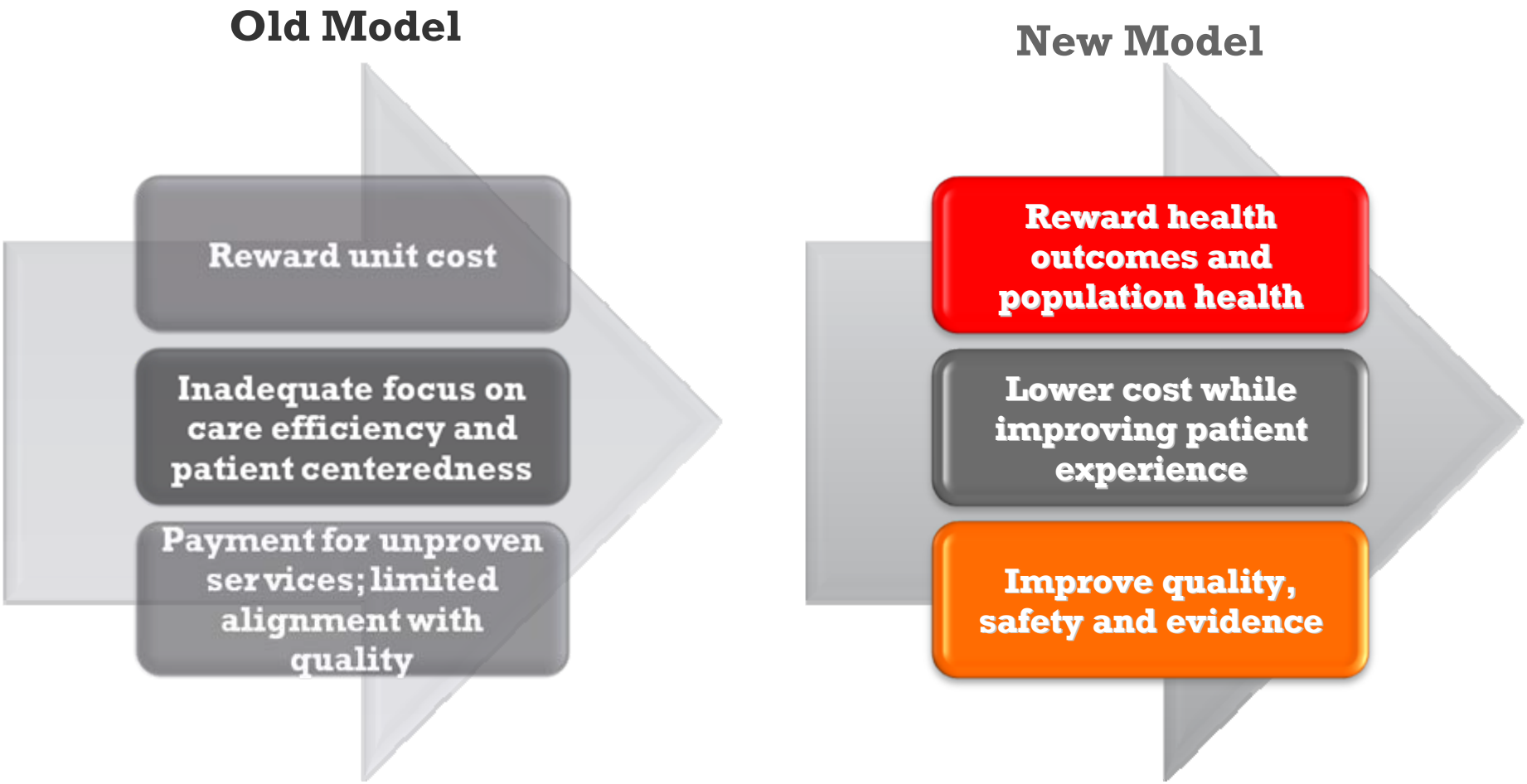
CMS Version, Circa 2010



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."**
- **Source: Berwick DM, "ACOs – Promise, Not Panacea," JAMA 308:10, September 12, 2012**

Payment and Delivery System Innovation: Improving Value And Affordability



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.**

- **Source: Oct. 30 Discussion Draft, "SGR Repeal and Medicare Physician Payment Reform," prepared by House Ways and Means committee and Senate Finance Committee staff. At http://waysandmeans.house.gov/uploadedfiles/sgr_discussion_draft.pdf**

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.**

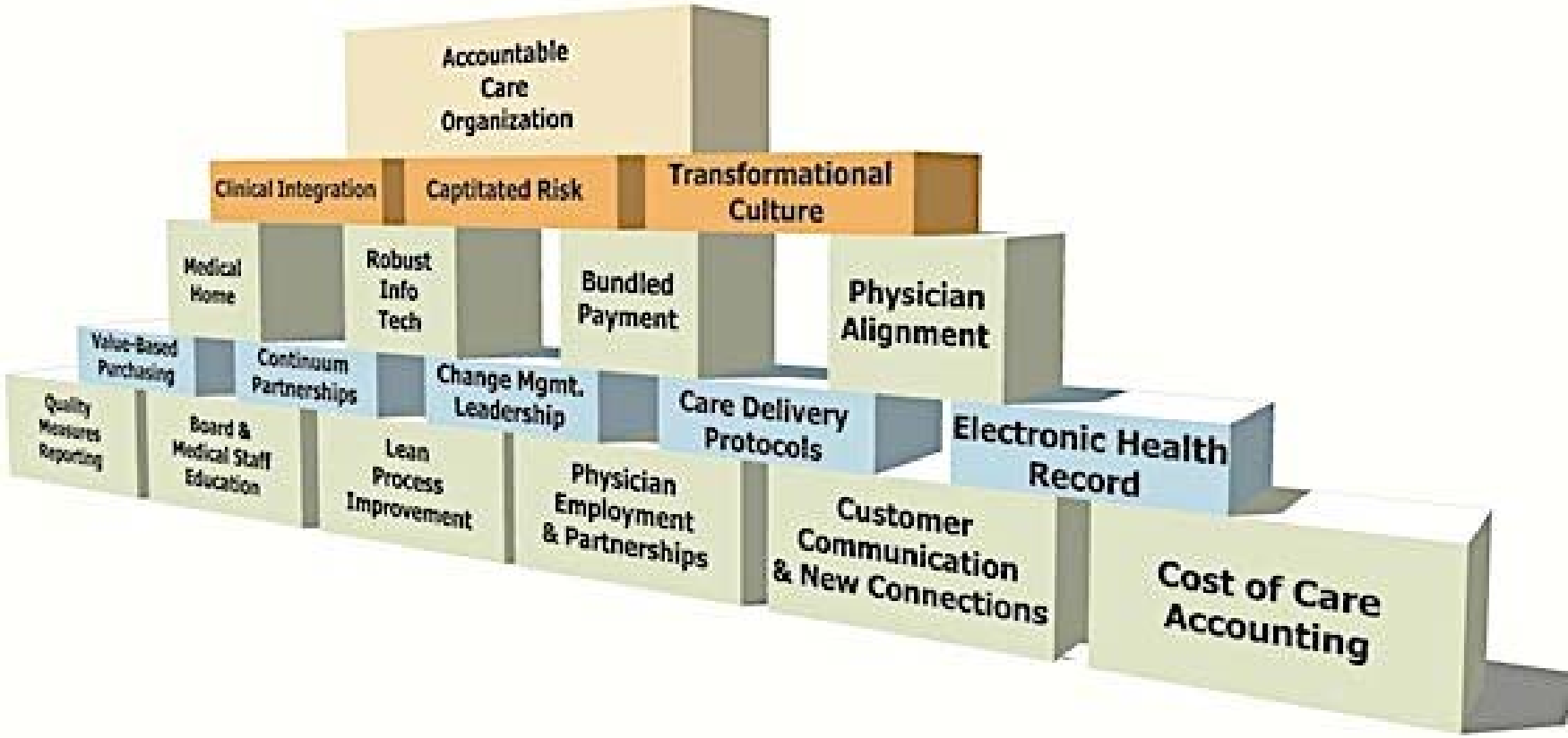
Key Elements of Transforming Care

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

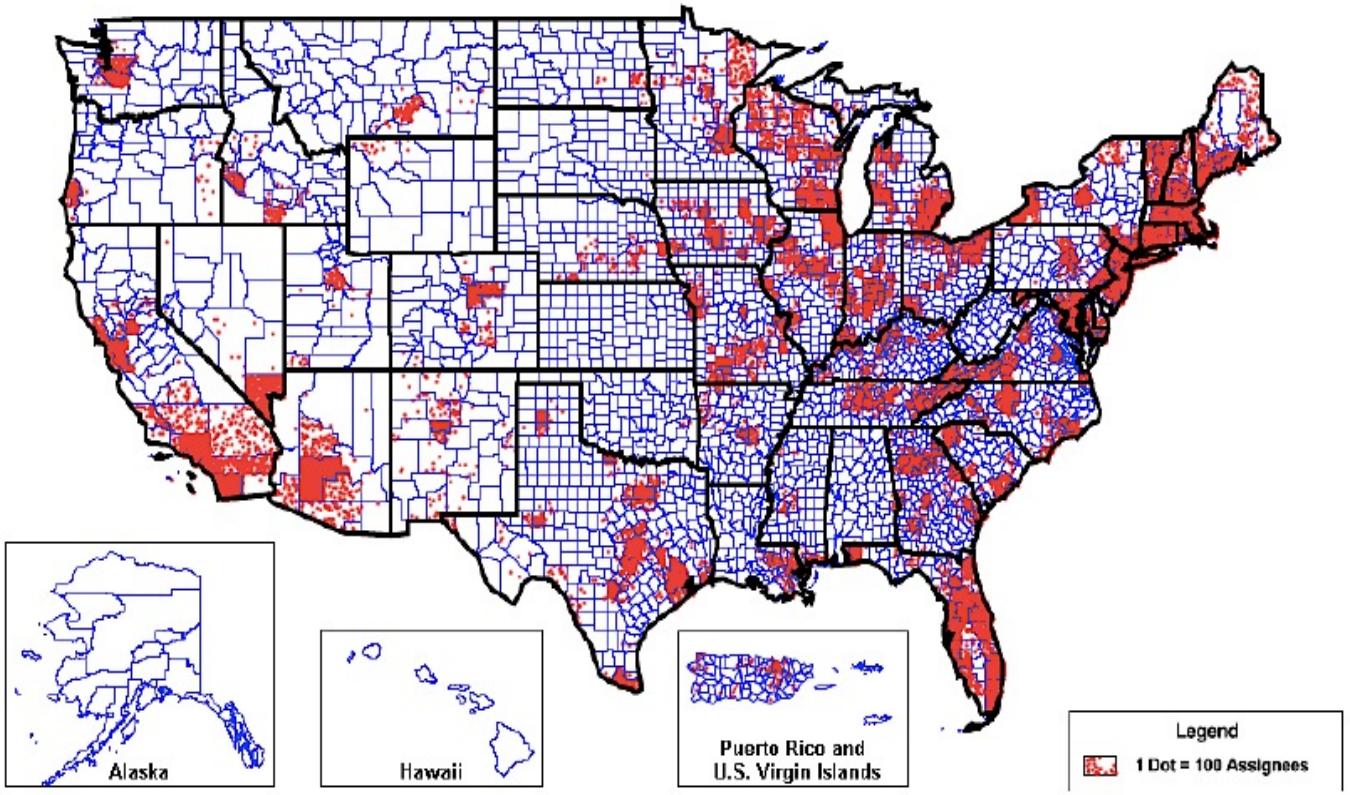
What exactly are the distinguishable features of ACO's?



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**

- **Source: McWilliams J et al, "Changes in Health Care Spending and Quality for Medicare Beneficiaries Associated With A Commercial ACO Contract," JAMA 2013; 310(8): 829-836**

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.O

- 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

IOM Variations Study: Recommendations

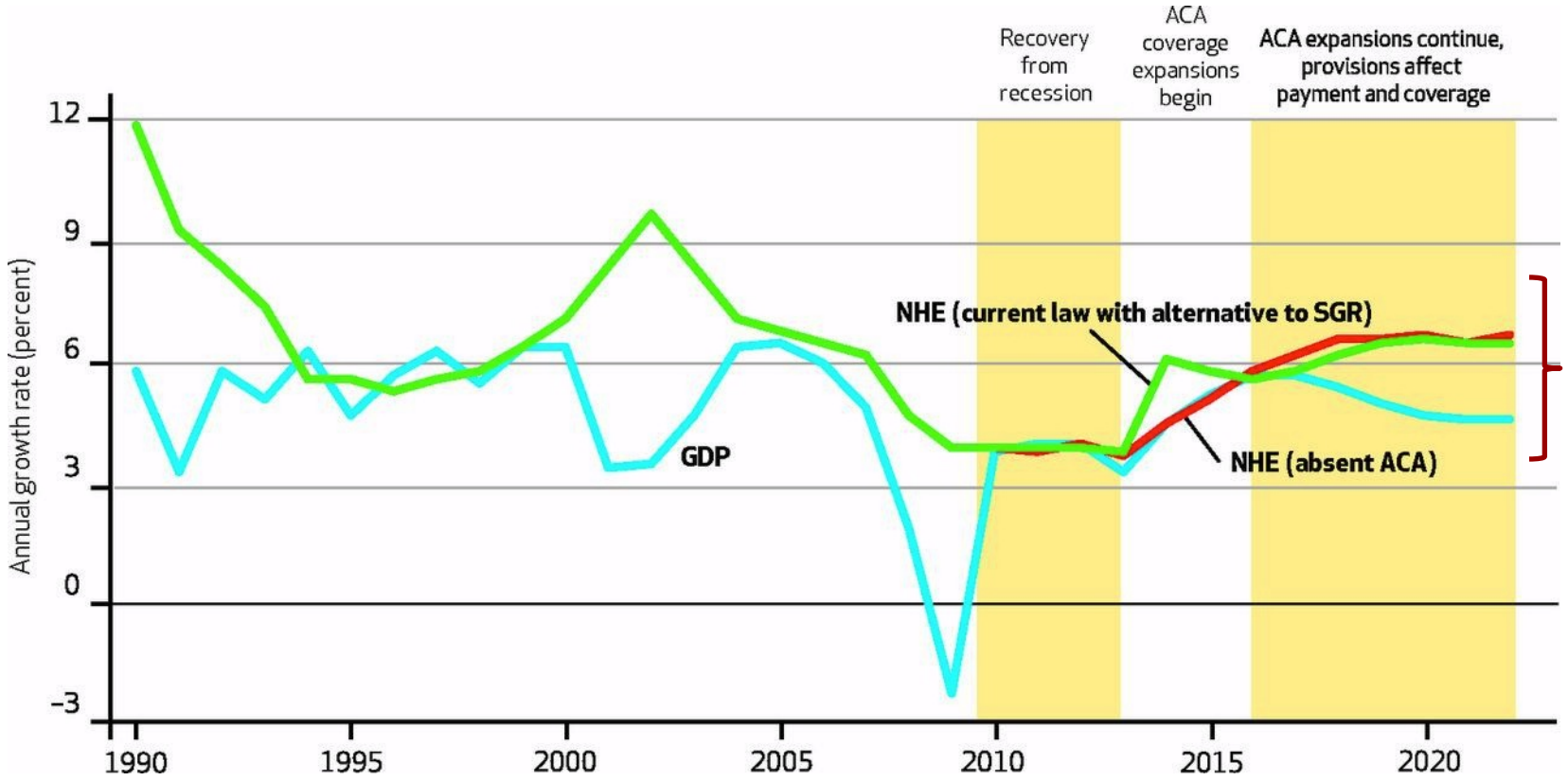
- **"RECOMMENDATION 3: To improve value, CMS should continue to test payment reforms that incentivize the clinical and financial integration of health care delivery systems and thereby encourage their**
- **(1) coordination of care among individual providers,**
- **(2) real-time sharing of data and tracking 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

Annual Growth Rates, Gross Domestic Product (GDP) And National Health Expenditures (NHE), Calendar Years 1990–2022.



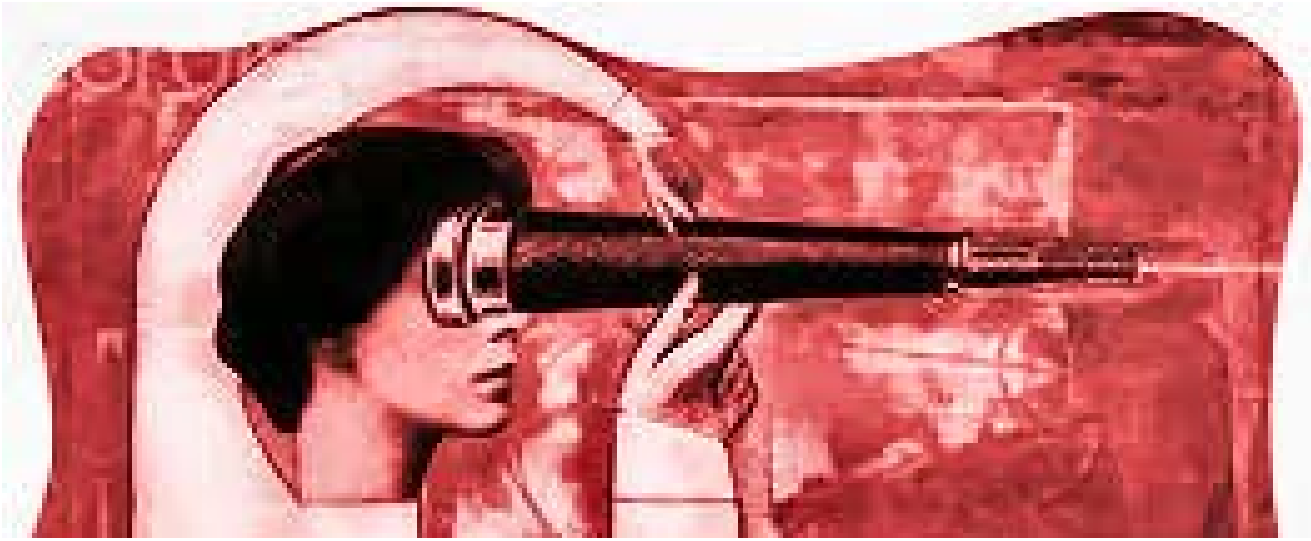
Cuckler G A et al. Health Aff doi:10.1377/hlthaff.2013.0721

HealthAffairs

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