ENGELBERG CENTER for Health Care Reform at BROOKINGS

Measuring and Improving Quality in Accountable Care Organizations

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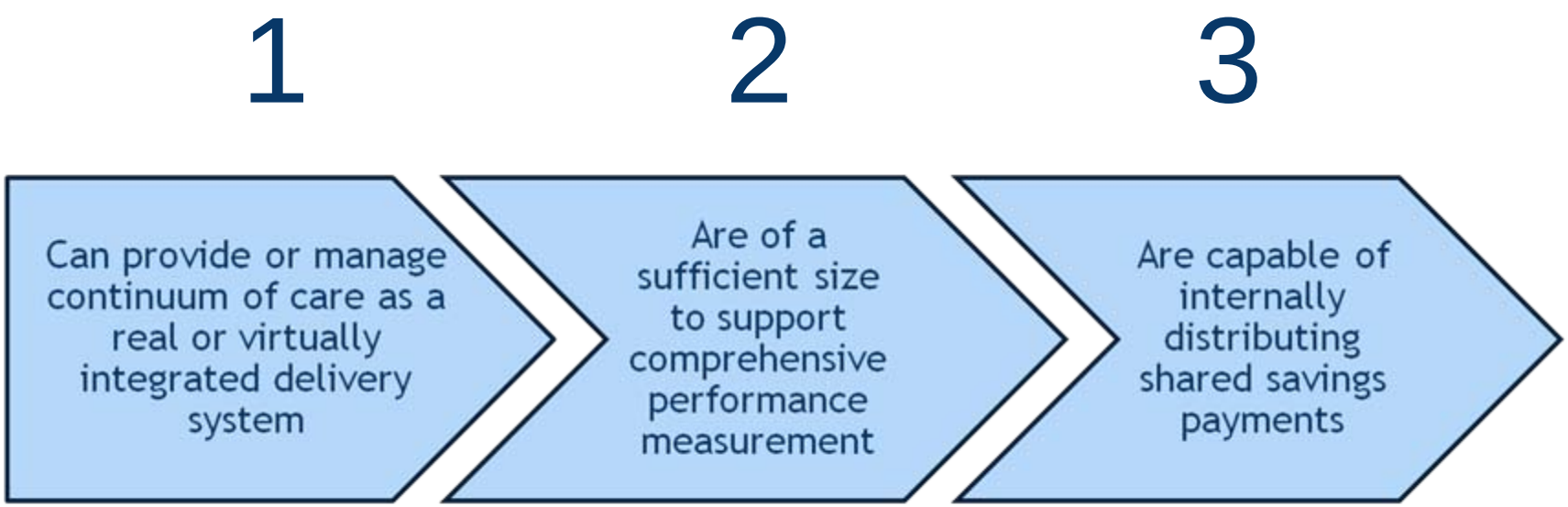
Overview

- ACOs and health care reform
- Key ACO elements
- Measuring and Improving Quality in ACO pilots

Wide Diversity of Possible ACO Designs

Integrated Delivery System	Multispecialty Group Practice	Physician-Hospital Organization	Independent Practice Association	Regional Collaborative
One or more hospitals & large group of employed physicians Insurance plans (some cases) Aligned financial incentives, advanced health IT, EHRs, & well-coordinated team-based care	Strong physician leadership Contract with multiple health plans Developed mechanisms for coordinated care (sometimes arranged through another partner)	Joint venture between one or more hospitals & physician group Vary from focusing contracting with payers to functioning like multi specialty group practices Many require strong management focused on clinical integration & care management	Individual physician practices working together as a corporation, partnership, professional corporation or foundation Often contract with health plans in managed care setting Individual practices typically serve non-HMO clients on a standalone basis	Independent or small providers Leadership may come from providers, medical foundations, non-profit entities or state government Sometimes in conjunction with health information exchanges or public reporting

Key Elements of an ACO



Important Caveats

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

Patient Attribution

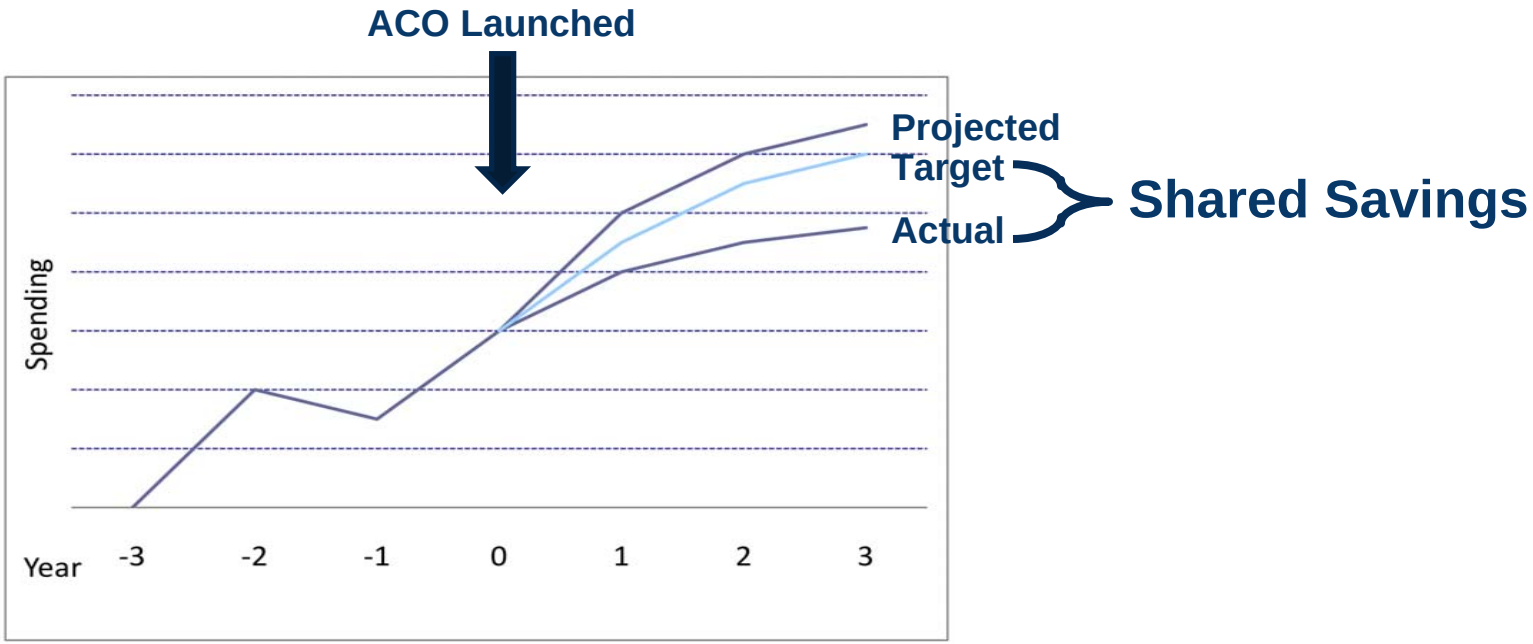
- Unique primary provider assigned for each patient
- Assigned based on where they received primary care in the past
- Minimizes "dumping" of high risk or high cost patients
- No "lock in" of patients to the ACO (not a gatekeeper model)

Important Caveats

- Accountability for assigned patients lies with the ACO, **not** individual providers alone
- Providers are part of the ACO **system** of care
- Providers affiliated with an ACO, even exclusively, can refer patients to non-ACO providers

Incentives Aligned with Aims

- **New payment model: shared savings if quality targets met**
  - Current per-capita spending for assigned patients determined from claims
  - Spending target is negotiated (private payers) or determined (Medicare)
  - If actual spending lower than target, savings are shared
  - **IF quality targets are also achieved**



Wide Range of Payment Models

Less risk  More risk

Level 1
Asymmetric Model

- 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

Meaningful Performance Measures

Measures should be outcome-oriented, span population and continuum of care, become more sophisticated along with growing care and health IT capacity

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

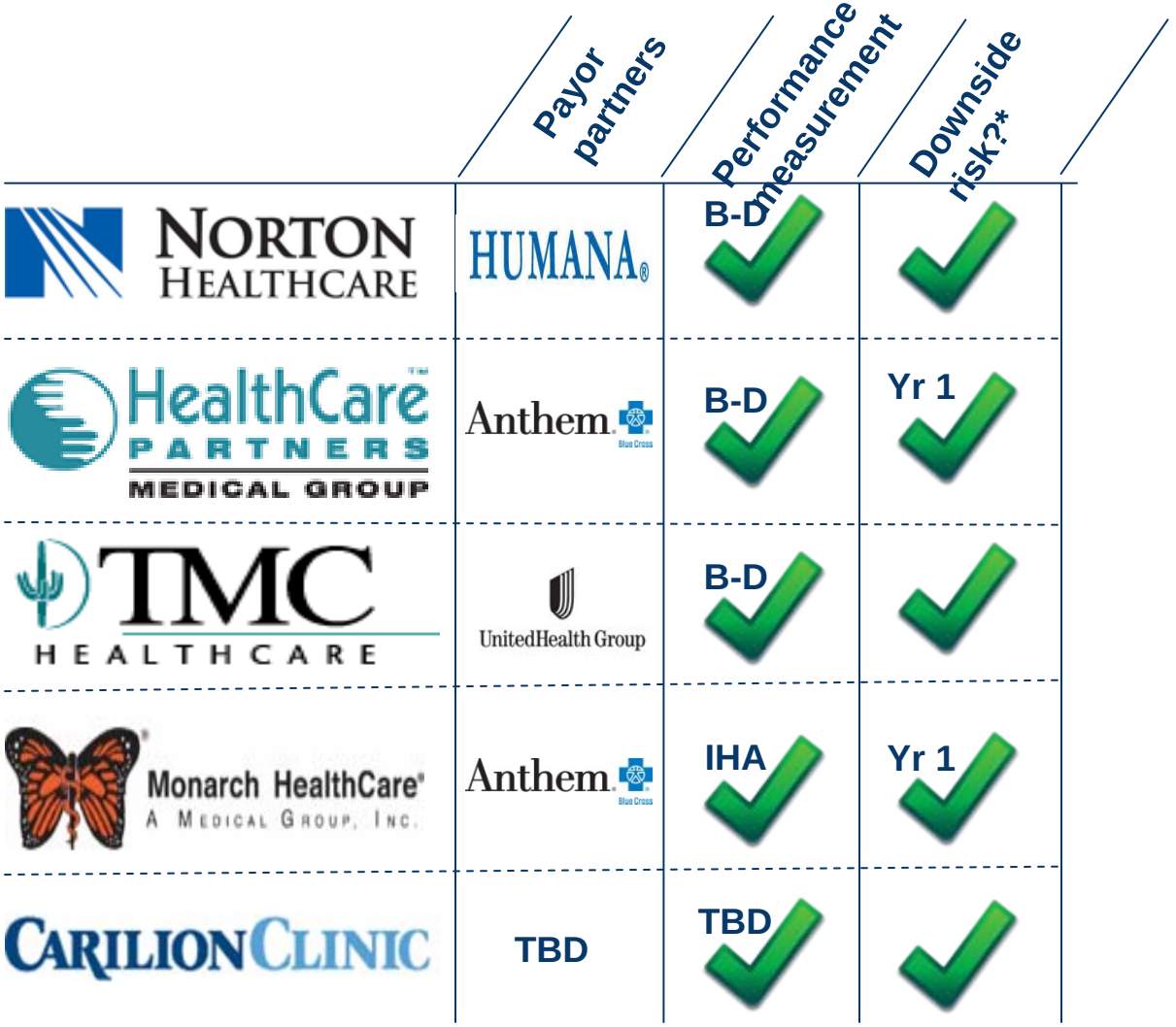
Advanced

- 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

Examples of ACO Pilots

	Brief Description
Medicare PGP	• 10 integrated multispecialty provider groups testing care reforms for Medicare beneficiaries under a shared-savings payment model (started 2005)
Medicare MHCQ (“646”)	• Builds on the PGP Demo by testing a similar payment and quality improvement model in multi-stakeholder organizations that include but are not limited to physician groups
Brookings-Dartmouth	• Initially five provider groups, ranging in size, type, and geography, implementing shared savings programs with commercial payers, with additional sites in process
Premier	• Roughly 25 “ACO ready” Premier provider systems working to implement shared savings programs within 1-2 years

Brookings-Dartmouth ACO Pilots



*All pilots plan to introduce downside risk within five years

Phase I Quality Measures – live 2010

Priority Areas	Initial Measures
Overuse	Use of imaging studies for low back pain
	Appropriate testing for children with pharyngitis
	Avoidance of antibiotic treatment for adults with acute bronchitis
	Appropriate treatment for children with upper respiratory infection (URI)
Population Health	Breast cancer screening
	Cervical cancer screening
	Diabetes: HbA1c management (testing)
	Diabetes: cholesterol management (testing)
	Cholesterol management for patients with cardiovascular conditions (testing)
	Use of appropriate medications for people with asthma
	Persistence of Beta-Blocker treatment after a heart attack
Safety	Annual monitoring for patients on persistent medications

Computed by plans based on consistent specs

Phase I Quality Measures – live 2010

Specific Measures (Potential)

Readmission

- All-Cause 30-Day Readmission Measure (NCQA)
  - Adjusted based on past co-morbidities, primary discharge conditions, age and gender.

Utilization

- Hospital days (per 1,000)
- Hospital admissions (per 1,000)
- Hospital admissions for ambulatory sensitive conditions (per 1,000)
- Emergency room visits (per 1,000)
- Emergency room to inpatient admission rates
- Use of generics drugs
- Doctor visit within 7 days of patient discharge
- Imaging rates (per 1,000)

Phase II Quality Measures – live 2011

Area	Clinically Enriched Measures	Measure Description
Coronary Artery Disease	Cholesterol management for patients with cardiovascular conditions	Percentage of patients with a cardiovascular condition who had a low-density lipoprotein cholesterol (LDL-C) screening performed and the percentage of patients who have a documented LDL-C level less than 100 mg/dL.
Coronary Artery Disease	ACE inhibitor or ARB therapy	Percentage of patients who also have diabetes and/or left ventricular systolic dysfunction (LVSD) who were prescribed angiotensin-converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy.
Diabetes	Low Density Lipoprotein (LDL-C) Control in Diabetes Mellitus	Percentage of patients aged 18 through 75 years with diabetes mellitus who had most recent LDL-C level in control (less than 100 mg/dl).
Diabetes	Hemoglobin A1c Poor Control in Diabetes Mellitus	Percentage of patients aged 18 through 75 years with diabetes mellitus who had most recent hemoglobin A1c greater than 9.0%.
Diabetes	HbA1c Control (<8.0%)	Percentage of members 18-75 years of age with diabetes (Type 1 and Type 2) who has HbA1c control (<8.0%).
Diabetes	High Blood Pressure Control in Diabetes Mellitus	Percentage of patients aged 18 through 75 years with diabetes mellitus who had most recent blood pressure in control (less than 140/80 mmHg).
Diabetes	Kidney Disease Screen	Percentage of members 18 through 75 years of age with diabetes mellitus (type 1 and type 2) who had a nephropathy screening test or evidence of nephropathy.

Phase II Quality Measures – live 2011

Area	Clinically Enriched Measures	Measure Description
Hypertension	**Blood Pressure Control**	**Percentage of hypertensive patients with last blood pressure < 140/90 mmHG.**
Pediatrics	**Childhood Immunization Status**	**Percentage of children 2 years of age who had four DtaP/DT, three IPV, one MMR, three H influenza type B, three hepatitis B, one chicken pox vaccine (VZV) and four pneumococcal conjugate vaccines by their second birthday. The measure calculates a rate for each vaccine and two separate combination rates.**
Pediatrics	**Immunization for adolescents**	**Percentage of enrolled adolescents 13 years of age who had one dose of meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) by their 13th birthday.**
Preventive Care	**Colorectal Cancer Screening**	**Percentage of patients aged 50 through 75 years who received the appropriate colorectal cancer screening.**

How are measures computed?

Measure types	Data collection and calculation performed by payer partners	Data collection and calculation performed by ACOs
Measures relying on administrative data only	Payers use standardized data queries of the administrative claims associated with the ACO and relevant measures to provide relevant performance results.	ACOs use payer-specific performance results to gain an understanding of their comprehensive performance.
Measures relying on administrative data and clinical data elements	Payers identify a membership population with relevant characteristics through their administrative data (e.g., population of health plan members with diabetes receiving care in the ACO – the denominator)	ACOs identify the necessary clinical data to measure intermediate outcomes for that population, such as blood sugar, cholesterol, or blood pressure levels (the numerator)

Phase III Quality Measures – live 2012

Specific Areas of Measurement (Potential)

Patient Experience

- Focus on three core domains:
  - Organizational access
  - Care coordination
  - Communication
- And two supplemental domains:
  - Self-management support
  - Knowledge of patients

» Data collection targeted to begin second half of 2011

Patient-Reported Outcomes

- Functional status
- Disease status
- Risk status

» Data collection targeted to begin late 2011/ early 2012

Tying performance to savings

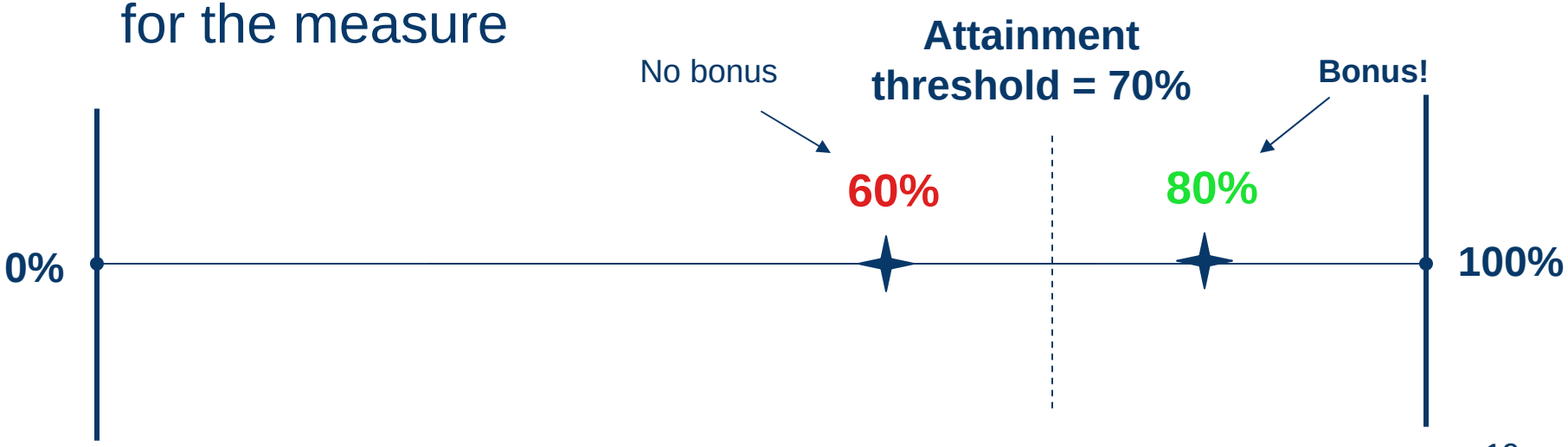
Target Setting Approach	Advantages	Disadvantages
Target Attainment	• Provides incentive to achieve and maintain performance above target, but not above that level • Process is easy to understand and target is clear to providers	• Very poorly performing ACOs are less likely to reach targets which can mitigate their incentive to improve care
Improvement	• Provides direct incentive to improve care	• May overemphasize rewards for ACOs with very low baselines
Combination of Target and Improvement	• Provides incentive to achieve and maintain performance above target, but not above that level. • Provides direct incentive to improve care.	• May overemphasize rewards for ACOs with very low baselines

Linking Performance to Payment

- An ACO payment model should…
  - Be simple/transparent
  - Reward performance and/or improvement
  - Be attainable
  - Be easy to administer

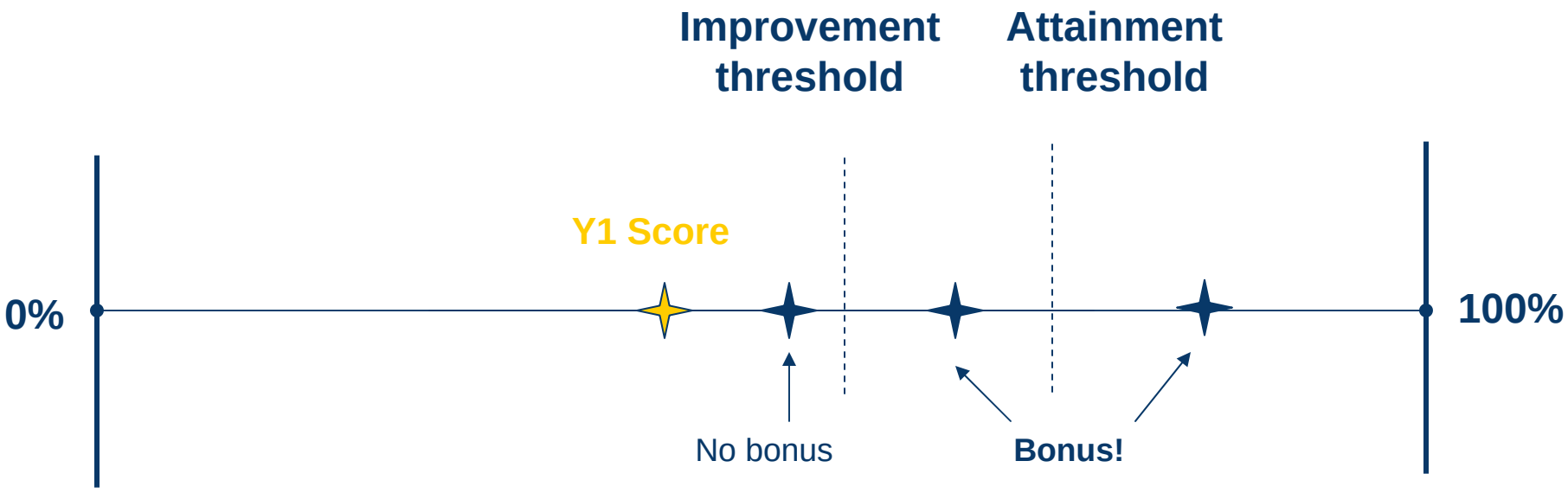
Target Attainment Threshold: Illustration

- Can set attainment thresholds by…
  - Using baseline performance
  - Using a pre-determined level of performance that reflects "good" care (e.g. 75% compliance)
  - Using a benchmark from a reference database (e.g. HEDIS 75th percentile) or a comparison group
- If the threshold is achieved, entity is awarded full credit for the measure



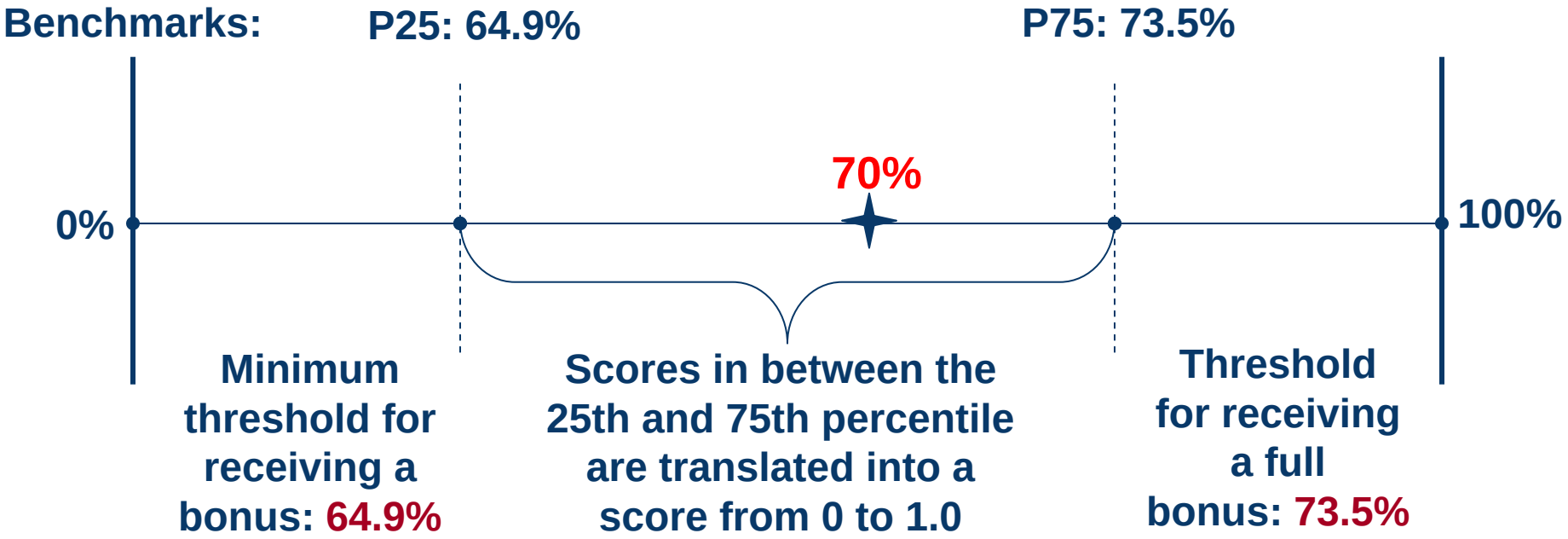
Attainment or Improvement: Illustration

- If either threshold is achieved, entity is awarded full credit for the measure



Target Attainment, Two-Threshold Continuum: Illustration

- A percentage of a point is awarded for each measure based on performance relative to a lower and upper threshold.



Range: 73.5 – 64.9 = 8.6

70 – 64.9 = 5.1;

5.1/8.6 = 0.6

Shared Savings and the ACO Pilots: Emerging Principles

- Each performance measure will have a minimum level of performance attainment (e.g., achieving the 50th percentile of a national or regional distribution of provider performance) for "earning" performance points, with more points earned based on how far the minimum threshold has been exceeded.
- A minimum number of points are needed across the performance measure set in order for the ACO to become eligible for shared savings. An ACO could achieve a sufficient number of points by significantly exceeding performance targets for most but not all measures.
- In addition to earning points for achievement, ACOs can earn points by demonstrating significant improvement since the last time their performance was measured.

Considerations

- Proportion of payment to be based on performance
- Determining individual measure thresholds
- Single threshold vs. Two-threshold continuum
- Composite score for payment*
  - How should composite score payment thresholds be determined?
  - How should measures/measure sets be weighted?
- Incorporating new measures
  - Phase-in period?

*Composite score for payment example in Appendix

Lessons learned to date

- Standardized, consistent measures is key
- Force “movement” by beginning with the “possible”; expand quickly into more measures
- Recognize diversity and adapt measure implementation approaches – focus on “equivalence” not “sameness”
- Leverage payer-provider partnership for making progress more quickly
- Build on and align with other public and private sector efforts.
- Create momentum by “doing”

Brookings-Dartmouth ACO Learning Network

Learn more at: www.ACOLearningNetwork.org

Conceptual → Implementation

2009-10 Network

- Focused on defining the ACO model and describing its technical components (e.g., patient attribution, performance measurement, etc.)
- Included regular webinars, ACO materials, and discounts to events
- **Over 100 members** including provider groups, payers, and policymakers

2010-11 Network

- Provides practical leadership on **how to implement an ACO** especially in light of emerging **Federal/state ACO regulations and pilots**
- Offerings include:
  - Implementation-focused webinar series
  - Exclusive member-driven conferences
  - Brookings-Dartmouth ACO newsletter
  - Web-based resources
  - ACO implementation groups
- Open to all parties interested in advancing accountable care – **1st webinar in late November**