Accountable Care Organizations: An old idea with new potential

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Testimony to Senate State Affairs

September 22, 2010

Impetus for ACO Formation

- Increased health care cost
  - From 1999 to 2009, health insurance premiums for family coverage increased 131%, from $5,791 to $13,375
  - Average per capita costs exceed $8,000, more than double the costs of other Western nations
- Publicly funded systems on unsustainable financial course
- Compared to other nations, U.S. has poorer health care outcomes yet has the highest costs

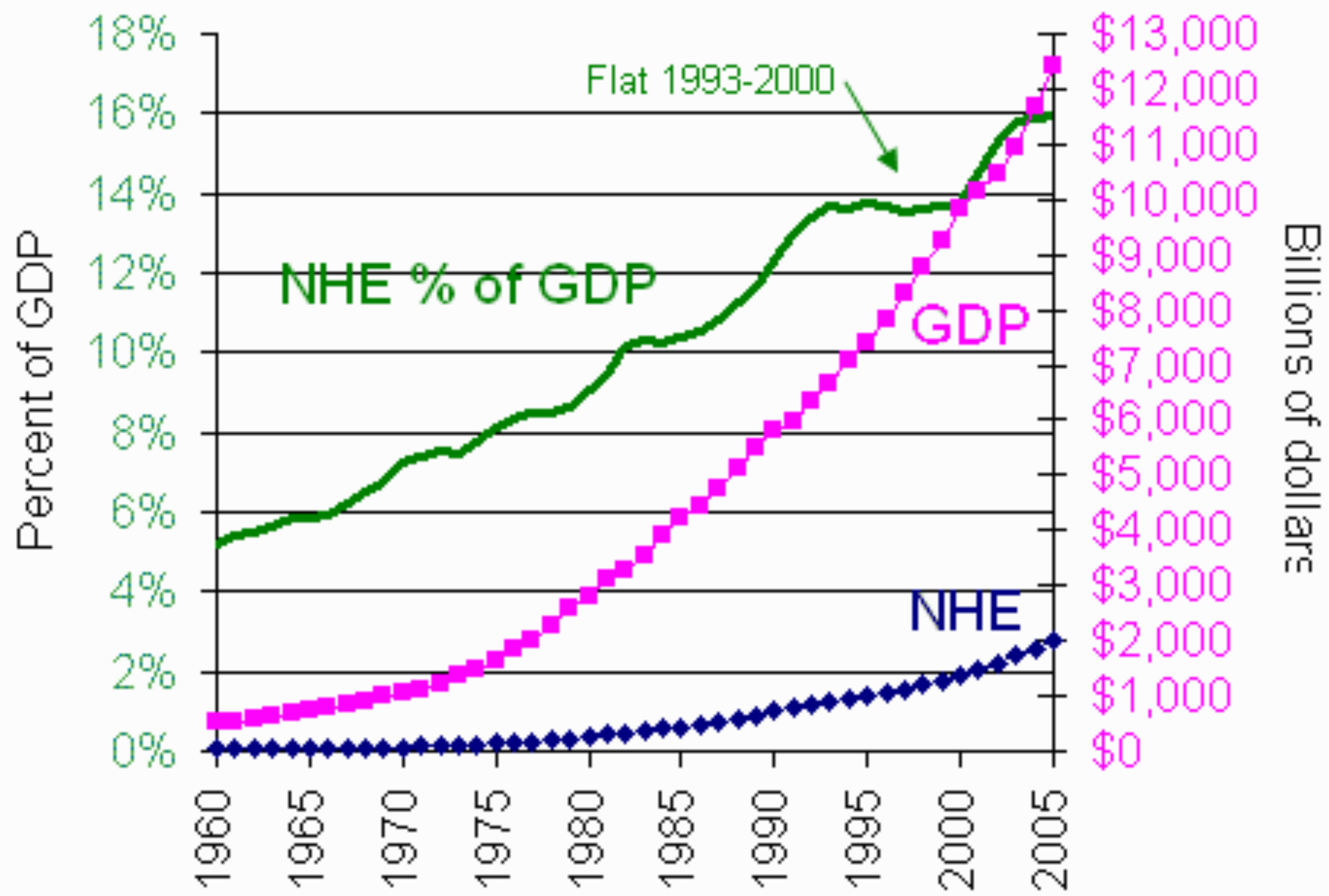
Average Annual Premiums for Single and Family Coverage, 1999-2009

Year	Single Coverage	Family Coverage
1999	$2,196	$5,791
2000	$2,471*	$6,438*
2001	$2,689*	$7,061*
2002	$3,083*	$8,003*
2003	$3,383*	$9,068*
2004	$3,695*	$9,950*
2005	$4,024*	$10,880*
2006	$4,242*	$11,480*
2007	$4,479*	$12,106*
2008	$4,704*	$12,680*
2009	$4,824	$13,375*

$0 $2,000 $4,000 $6,000 $8,000 $10,000 $12,000 $14,000 $16,000

* Estimate is statistically different from estimate for the previous year shown (p<.05).

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2009.



Flat 1993-2000
NHE % of GDP
GDP
NHE
Percent of GDP
Billions of dollars
18%
16%
14%
12%
10%
8%
6%
4%
2%
0%
$13,000
$12,000
$11,000
$10,000
$9,000
$8,000
$7,000
$6,000
$5,000
$4,000
$3,000
$2,000
$1,000
$0
1960
1965
1970
1975
1980
1985
1990
1995
2000
2005

Impetus for ACO Formation

- Public and private payers want greater value and predictability for their health care dollars; payers want less variation in health care spending
- Concerns about how current payment models may result in misaligned incentives, e.g. rewarding physicians and hospitals for high-cost, high-volume services. Instead of improving quality and patient outcomes
- Desire to foster greater care coordination across providers to improve health outcomes, e.g. hospital readmissions
- Desire to promote and foster preventive and primary care services and reduce health care inequality

Background/History

- 18 months ago, few policy makers or physicians were familiar with the ACO model. Today, a Google search for the term “Accountable Care Organization” reveals more than 300,000 hits
- Actual term emerged in 2006 when Dartmouth Institute proposed a Virtual medical staff organization as a means to better coordinate care for Medicare patients
- In 2007, Dartmouth and the Brookings Institution joined forces to create the ACO Learning Collaborative to help foster model nationally

Background/History

- However, “accountability” movement is not new:
  - Group and IPA model HMOs
  - Medicare group practice demonstration
  - Medical home initiatives
  - Provider Sponsored Organizations
  - Physician-Hospital Organizations (PHOs)
  - A variety of capitation models from managed care insurers

Background/History

- In 2009, model gained tremendous momentum:
  - ACO concept incorporated into early drafts of health system reform legislation
  - Texas legislators propose legislation to reform Medicaid and ERS delivery/payment systems by relying on ACO concepts
  - MedPAC releases paper promoting ACO option in Medicare
  - Legislatures in Colorado, Vermont and Massachusetts also take up ACO legislation
  - Baylor Health Care System in Dallas announces its intention to become ACO in 3 years
  - DFW hosts an ACO “summit” bringing together medicine, hospitals, insurers, employers, and community leaders
  - Dartmouth/Brookings foster ACO pilots in commercial arena

Background/History

- March 23, 2010: President Obama signs PPACA, which includes ACO pilots. Multiple provisions of PPACA encourage ACOs and complimentary efforts to drive accountability
  - Establishes the new Center for Medicare and Medicaid Innovation to test new payment and delivery models ($10 billion allocated over 10 years).
  - Expands CMS' efforts to bundle payments around episodes of care and authorizes Medicaid bundled payment pilots.
  - Funds the Patient-Centered Outcomes Research Institute to explore and compare evidence-based medical treatments.

Background/History

- Establishes Medicare ACO pilot as well as a Medicaid pediatric ACO pilot (2012)
- Establishes a Medicaid pilot to test global capitation system in safety-net hospitals (2010)
- Provides enhanced funding for state Medicaid programs that implement medical home initiatives for patients with chronic conditions (2011).
- Establishes grant funding to support development of community health teams as well as preventive and public health programs

Background/History

- ACOs have been compared to HMOs of the 1980's and 1990's
- Similarities include:
  - Reliance on provider "skin in the game" to achieve change in behaviors
  - Shifting of risk
  - Patient assignment (possibly) to a defined entity
  - Tightly managed or closed networks

Background/History

- **Differences**
  - Focus is on the primacy of physicians and hospitals instead of health plans (insurers)
  - More sophisticated tools to measure health care quality and physician/provider performance
  - Advances in severity/risk adjustment technologies
  - Advanced used of Health Information Technology
  - Address broader public health goals, e.g. obesity
  - Engage patients via patient satisfaction surveys
  - Incorporate evidence-based medicine

What is an ACO?

- *An ACO is defined as a local entity and a related set of providers, including at least primary care physicians, specialists and hospitals that can be held accountable for the cost and quality of care delivered to a defined subset of traditional Medicare program beneficiaries or other defined populations, such as commercial health plan subscriber.*

What is an ACO?

- Entities eligible to be an ACO include:
  - IPA
  - Multispecialty Physician Group
  - PHO
  - Integrated Delivery System
  - "Virtual" ACO
- Depending on the market, there may be multiple ACOs to avoid "forced marriages"

What is an ACO?

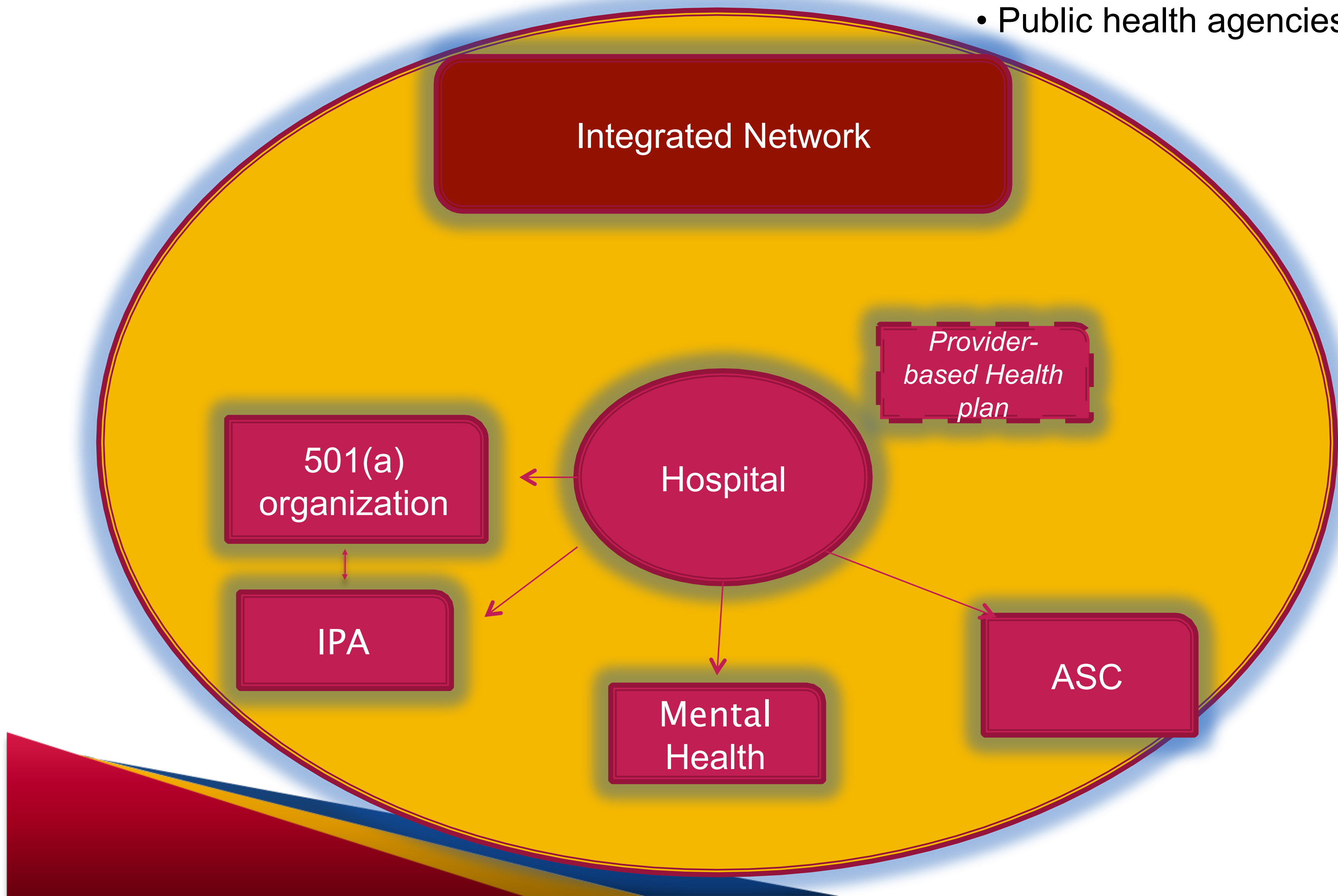
PCP Group

Community Hospital

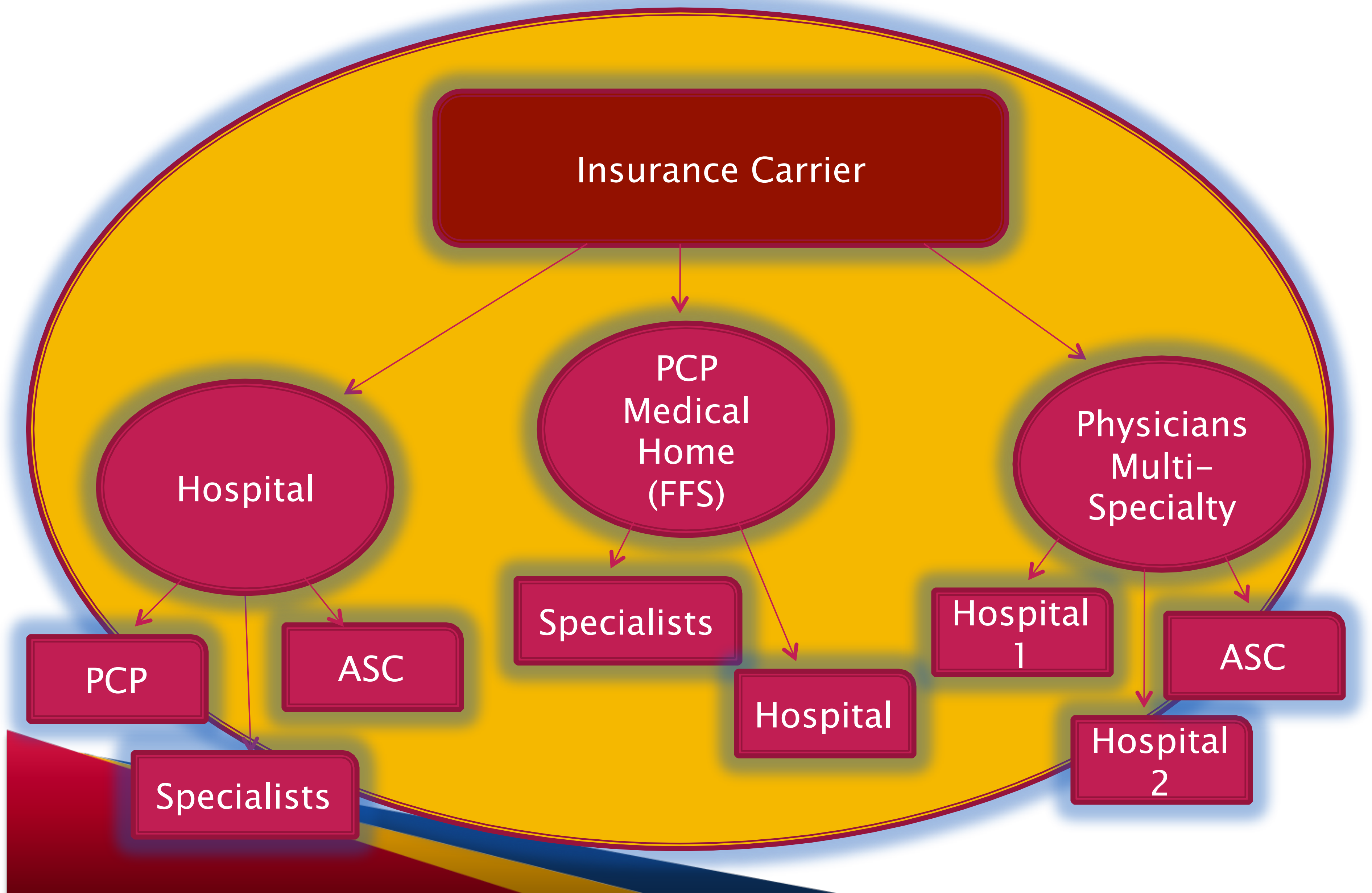
What is an ACO?

What is an ACO?

Community Partners
- Foundations
- Public health agencies



What is an ACO?



What is an ACO?

- Ultimately, the structure is less important than the outcomes it produces. The model is meant to be adaptable to different markets (which also helps explains its popularity)
- There is no ACO certification process yet. But entities commonly referred to as “ACOs” include, Mayo Clinic, Geisinger, Intermountain Health Care, Virginia Mason Health System, Scott and White, and programs like Project Access in Dallas.

Key Features

- Local accountability for the quality and costs of patients participating in the ACO
- Ability to prospectively establish the organization's budget and resource needs
- Ability to reliably and accurately measure performance and use the results to drive improvement

Key Features

- Capability to provide or manage patient care across a continuum of settings
- Willingness to implement payment incentives that reward healthcare quality and promote coordination of care
- Transparency for payers and consumers
- Regardless of structure, the ACO is held accountable for total spending and quality for a defined population

What is a Medicaid ACO?

- Health System Reform establishes a Pediatric ACO demonstration project (Sec. 2706).
  - Pilot begins in 2012
  - CMS Secretary will establish guidelines to ensure that the quality of care by the ACO is not less than the quality of care that would have been otherwise
  - Participating States, in consultation with the Secretary, shall establish an annual minimal level of savings that must be reached by an ACO in order for the incentive to be paid. 2012-2016.

What is a Medicaid ACO?

- Health System Reform establishes a Pediatric ACO demonstration project (Sec. 2706) (continued).
  - An ACO must commit for 3 years.
  - The State must apply to be part of this project. ACO participation is dependant on the State Medicaid Program's decision to participate. Texas Health and Human Services Commission has indicated it will pursue pilot.

What is a Medicare ACO?

- Health System Reform legislation also established the new Medicare Shared Savings *Program* (Sec. 3022)
- Goals:
  - Promote accountability for a patient population
  - Coordinate items and services under parts A and B
  - Encourage “high quality and efficient service delivery” and investment
    - In infrastructure and
    - Redesigned care processes.

What is Medicare ACO?

- Entities eligible to form a Medicare ACO:
  - Professionals in group practice arrangements
  - Networks of individual practices of ACO professionals
  - Partnerships or joint venture arrangements between hospitals and ACO professionals.
  - Hospitals employing ACO professionals.
  - Other forms the Secretary determines appropriate.

What is a Medicare ACO?

- Statutory Requirements
  - Be accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to it.
  - Enter into a 3-year contract with the government.
  - Have a formal legal structure permits it to receive and distribute payments.
  - Sufficient primary care “professionals” sufficient for the number of beneficiaries in the ACO which is at least 5,000 beneficiaries.

What is a Medicare ACO?

- Have a leadership structure that includes clinical and administrative systems.
- Have defined processes to promote evidence-based medicine and patient engagement, report on quality and cost measures, and coordinate care.
- Be patient-centered using patient or the use of individualized care plans.

What is a Medicare ACO?

- Payment
  - Fee-for-service payments shall continue to be made
  - A participating ACO *is eligible* to receive payment for shared savings if:
    - The ACO meets quality performance standards and actually achieves saving.
    - That payment is a percent the difference between the estimated average per capita Medicare expenditures in a year (risk-adjusted) as compared to historical benchmark for the ACO. The remainder of such difference shall be retained by the government.

What is a Medicare ACO?

- May provide payments for acute care episodes, partial capitation, or payment method approved by the HHS Secretary that promote quality
- No payment penalties for failure to meet savings targets (at least for now)

What is a Medicare ACO?

- Patient Assignment
  - Medicare beneficiaries will continue to be able to choose their physician and other providers
- Draft rules to be published in fall 2010; sign up for CMS Open Door Forums to stay current: www.cms.gov/ OpenDoorForums

Paying for Accountability

Projected spending

benchmark

ACO Launch

SAVINGS

Spending

Actual spending

Time

Source: Brookings-Dartmouth ACO Collaborative

Paying for Accountability

- How will savings be achieved?
  - Increasing care coordination/case management
  - Reducing potentially preventable hospitalizations and readmissions
  - Improving patient safety
  - Promoting increased use of primary care, prevention and wellness
  - Standardization of care and services

Paying for Accountability

- Bundled Payments
- Partial Capitation
- Full Risk Capitation

TMA Position

- TMA supports testing ACOs, bundled payments and other reforms within Medicaid and ERS

TMA Position

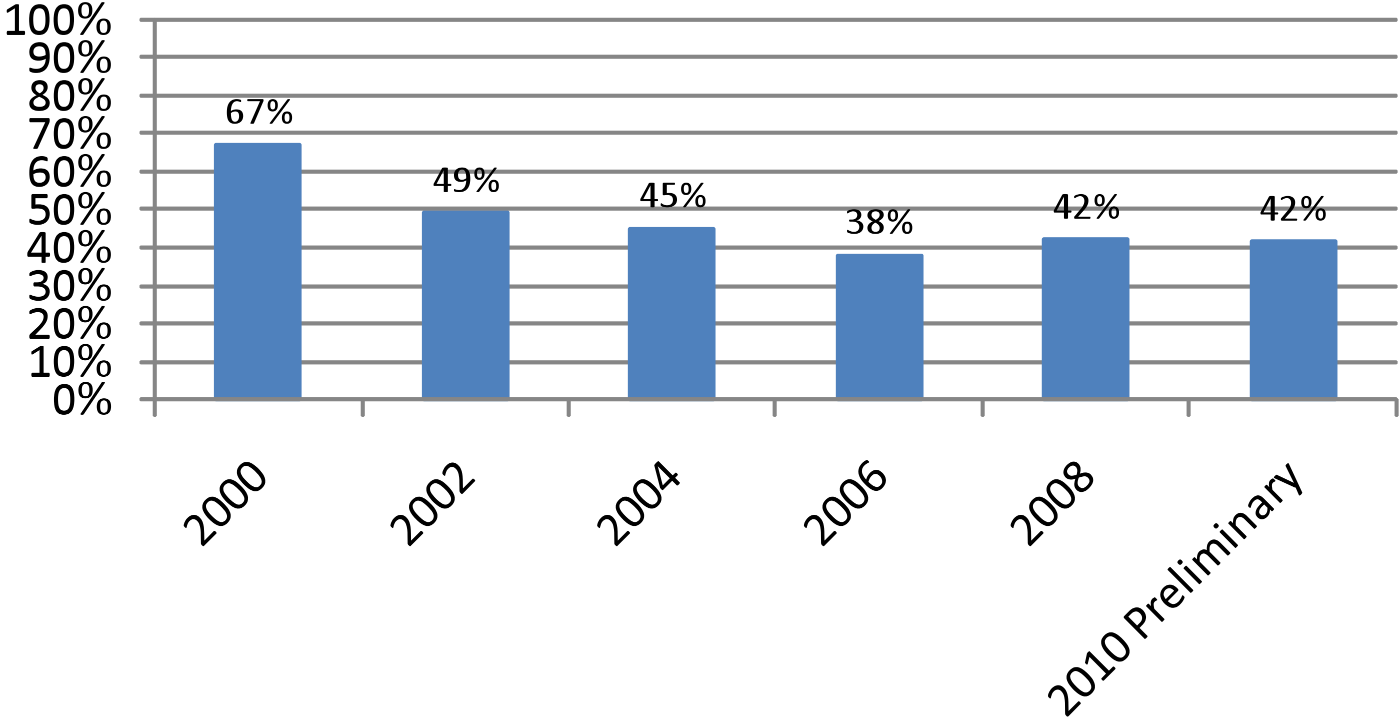
- Principles for reform:
  - Ensure voluntary participation by physicians
  - Actively involve local physicians and hospitals in the design, implementation, monitoring and evaluation.
  - Ensure pilot participation is of sufficient length to ensure valid and reliable evaluation of the pilot's impact on health outcomes.
  - Focus pilots on illnesses considered high volume, high cost, and/or high risk.
  - To the extent possible, coordinate Medicaid initiatives with initiatives underway in ERS, commercial insurers and Medicare

TMA Position

- Ensure that performance measures are:
  - Evidence-based, nationally-recognized, transparent and routinely updated to reflect changes in clinical practice;
  - Developed by consensus and applicable to the population;
  - Limited in number, published in advance, and easily collected and measured using current data systems
- Ensure appropriate due process protections for participating physicians and hospitals
- Use positive financial incentives instead of penalties
- Invest resources to monitor, evaluate and disseminate information to physicians/providers on emerging best practices

TMA Position

- Improving Medicaid accountability and achieving meaningful savings will hinge on having a robust Medicaid physician network
- Today, only 42% of physicians report seeing all new Medicaid patients; in 2000, 67% reported same
- Medicaid payments average 73 of Medicare and 50 percent of commercial payments.
- Lack of competitive rates will discourage physicians from developing or participating in Medicaid ACOs or other initiatives.


Percent of Texas physicians who will accept all new Medicaid patients
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
67%
49%
45%
38%
42%
42%
2000
2002
2004
2006
2008
2010 Preliminary

TMA Position

- TMA House of Delegates instructed formation of an Ad Hoc Workgroup on ACOs to help TMA develop policy as well as practical tools to help physicians respond to a changing environment.
- 12-member committee appointed in July composed of primary care and subspecialty physicians from across the state

Challenges to ACO Formation

- Texas predominantly organized around small and solo practices, so most practices not primed for ACO movement
- Requires intensive capital to set-up and maintain
- Developing necessary physician culture to facilitate ACO model takes decades not months
- Numerous legal barriers without sufficient guidance

Challenges to ACO Formation

- Patients may view ACO as just another HMO
- Unrealistic expectations about impact of ACOs on quality and costs
- May result in repeat of previous financial failures of provider-led organizations
- Temptation to curtail necessary care if incentives not right
- Consolidation of markets could increase health care costs
- Still lots of road bumps on road to widespread HIT deployment, which will be critical to ACO long-term success

Will ACOs Succeed?

- CBO projects $5 billion in savings for Medicare ACO program over 8 years and increasing steadily. However….
- Previous attempts at reducing costs via efforts to enhance preventive care, increase care coordination, and manage chronic diseases all show mixed results or may actually increase cost
- Initiatives such as the medical home model – a central element of the ACO concept – proving difficult and costly to implement; widespread adoption still far off
- Studies also show improvements not equalized across physicians/providers – higher performing practices get better while poorer performing groups show little or no improvement
- Success may hinge on the size of bonus payments/incentives offered as well as how many patients in the practice are impacted