

Accountable Care Organizations

Bending the Cost Curve, Breaking the Rules

American Academy of Medical Administrators

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Questions to ask

1. What is an accountable care organization?
2. What is accountable care?
3. What should I do?
 - a. Educate
 - b. Evaluate
 - c. Participate, or
 - d. Negotiate

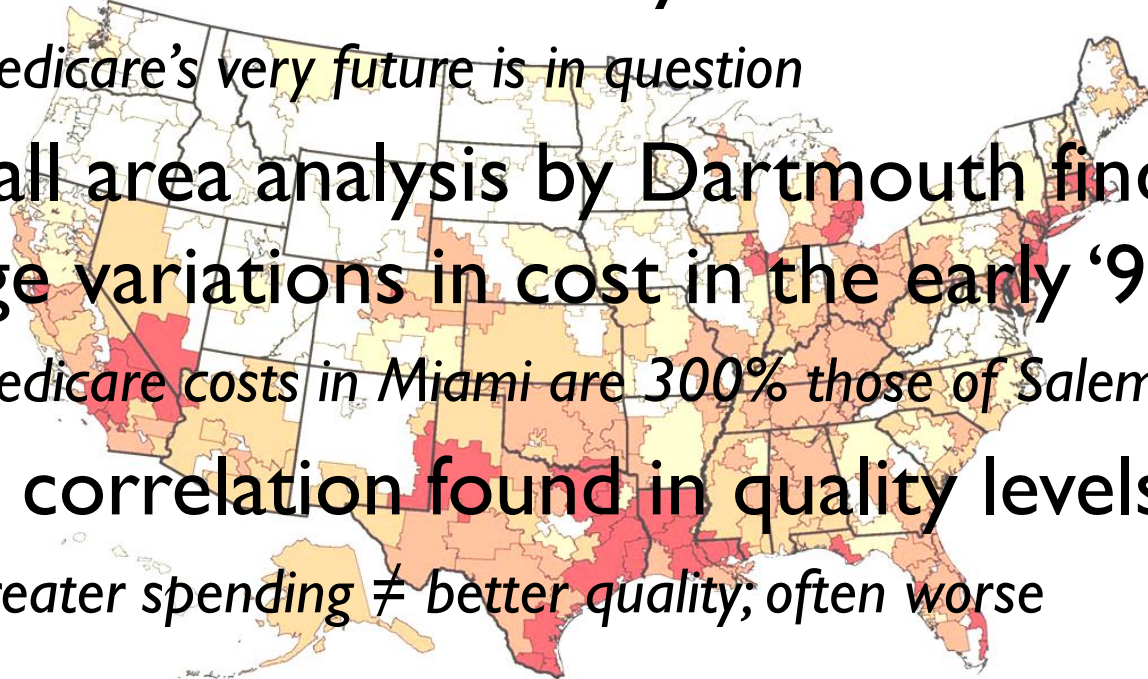


Accountable: definitions in use

1. N., “Accountable care” is concept born of analyzing regional variation
2. N., An “accountable care organization” was envisioned as an idealized entity that could be held responsible for bringing Salem care to Miami and El Paso care to McAllen by employing new strategies and structures
3. N., An “Accountable Care Organization” is an entity that meets the eligibility criteria to participate in Medicare’s Shared Savings Program
4. N., An “*Accountable Care Organization*” is a self-designation applied to themselves by hospitals, health systems and medical groups
5. N., An “*Accountable Care Organization*” is one that is prepared to perform well under global payment contracts

Tracing the roots of accountability

- A growing concern and sense of doom over the cost of medical care pervades the medical community.
 - *Medicare's very future is in question*
- Small area analysis by Dartmouth finds large variations in cost in the early '90's
 - *Medicare costs in Miami are 300% those of Salem, OR*
- No correlation found in quality levels
 - *Greater spending ≠ better quality; often worse*



What causes variation?

- Fee for service results in perverse incentives
 - *Do more, make more; do less, make less*
- Fragmented providers
 - *Nearly 50% of all physicians practice in private groups of 5 or fewer physicians*
- Fragmented payers
 - Multiple payers in most markets with different payments systems and incentives
- Specialization
 - *Promotes supply-sensitive demand and minimizes the role of and resources for primary care*

It's OK to be confused. Even Don Berwick is confused...

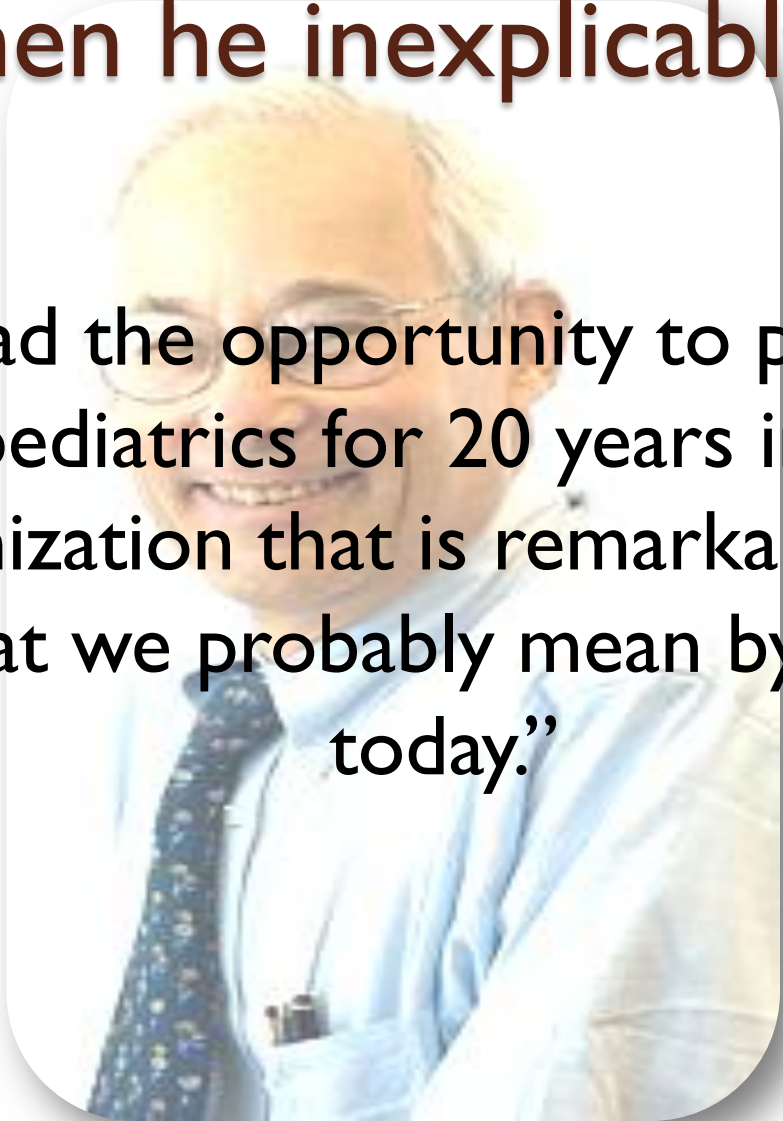
“The ACO I imagine is not the status quo repackaged.”

“There is no one-size-fits-all model for an ACO. The rural may not look like the urban one.”

“Those who wish to only preserve the status quo under a new name are not going to be constructive contributors to the Nation's future.”

October 5, 2010 ACO Workshop Sponsored by CMS/OIG/FTC

But then he inexplicably says:



**“I had the opportunity to practice
pediatrics for 20 years in an
organization that is remarkably close
to what we probably mean by an ACO
today.”**

October 5, 2010 ACO Workshop Sponsored by CMS/OIG/FTC

RHS Accountable Care Principles:

1. It is **Population**-based:
 - For Payment (replacing and/or supplementing FFS)
 - For **Health Status** (not simply “Quality”)
2. Payment is for **Results** (not just for **performance**):
 - Payment for improving a population’s health, not just the reduction of process or procedure **defects**)
 - Causing waste costs providers, eliminating waste benefits providers
3. It elevates, promotes and increases **Primary Care**
 - PCPs move out of the practice, through the medical home and into the **boardroom**
 - The reallocation of waste and capacity grows Primary Care income and ultimately their numbers
4. It seeks to reduce **Waste** reducing
 - Fewer unnecessary procedures
 - Weaker demand → → **capacity reduction**
 - Less capacity → → less demand (of supply sensitive services)
5. It reduce **Fragmentation** by promoting integration without assimilation

Fundamental misconceptions

Austin Frakt, Assistant Professor of Health Policy and Management
Boston University's School of Public Health in the Kiaser Health News,
Nov 03, 2010, defines **Accountable Care Organization** as ...

“... an integrated delivery system would be responsible for providing all the health care required by a defined population. Higher quality and lower cost would be rewarded through a new type of administrative payment system, yet to be developed and tested. This could put more of the cost risk on providers.”

This has been tried as a capitated HMO; this has a bonus twist.

Missing accountable care elements:

- ✓ Primary care's central role in decision-making and as the principle bonus or incentive recipient
- ✓ A focus on waste (capacity) reduction not improvement
- ✓ Responsibility for **health**, not just health care

ACOs are ...

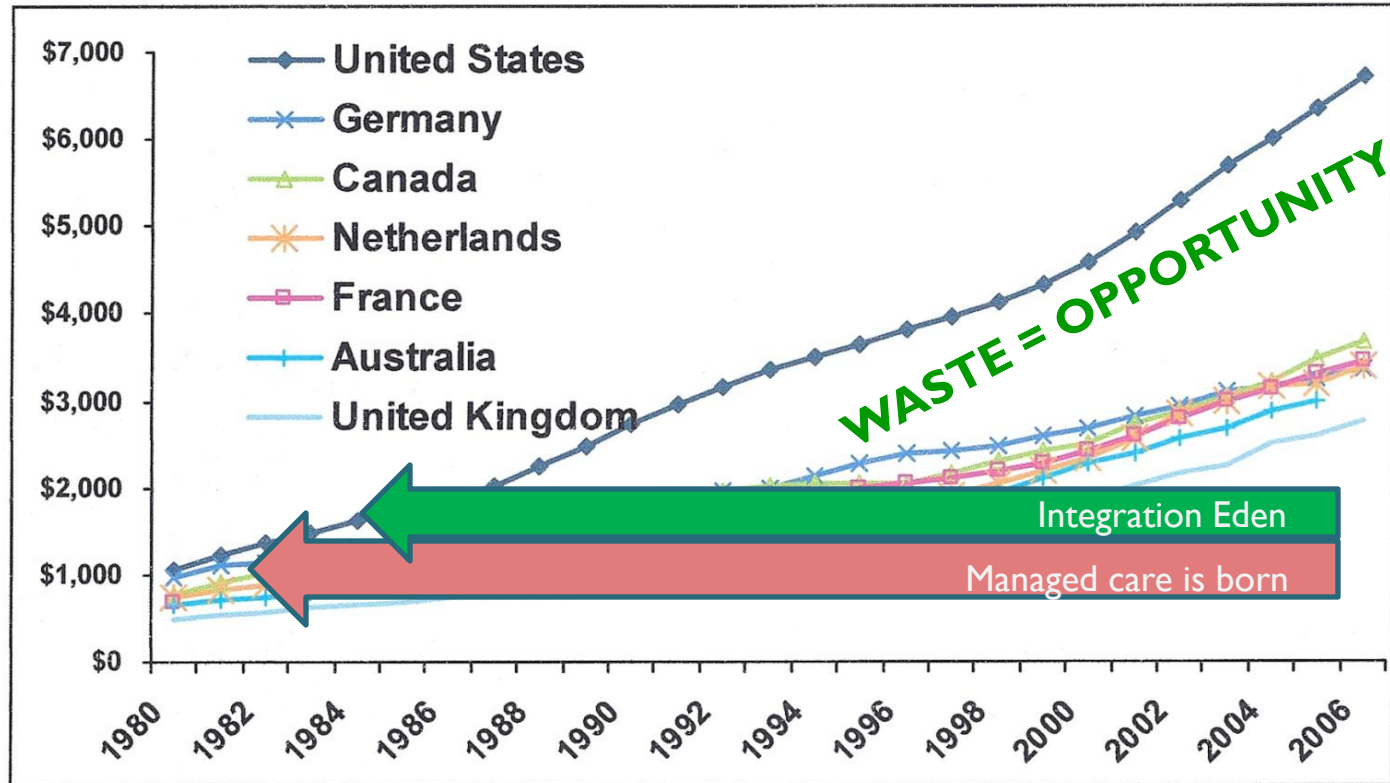
... groups of providers (failing to emphasize Primary Care's new dominance) that have the legal structure to receive and distribute payments to participating providers (presumes that all providers necessary are owners), to provide care coordination (no indication of the need to reduce demand), to invest in infrastructure (adding costs rather than removing them) and redesign care processes (emphasis on efficiency rather than reduction or replacement) , and to reward high quality and efficient services (failing to emphasize redistribution from specialty to primary care and the reduction of capacity).

Shortell, Casalino, Fisher May 2010

Healthcare spending

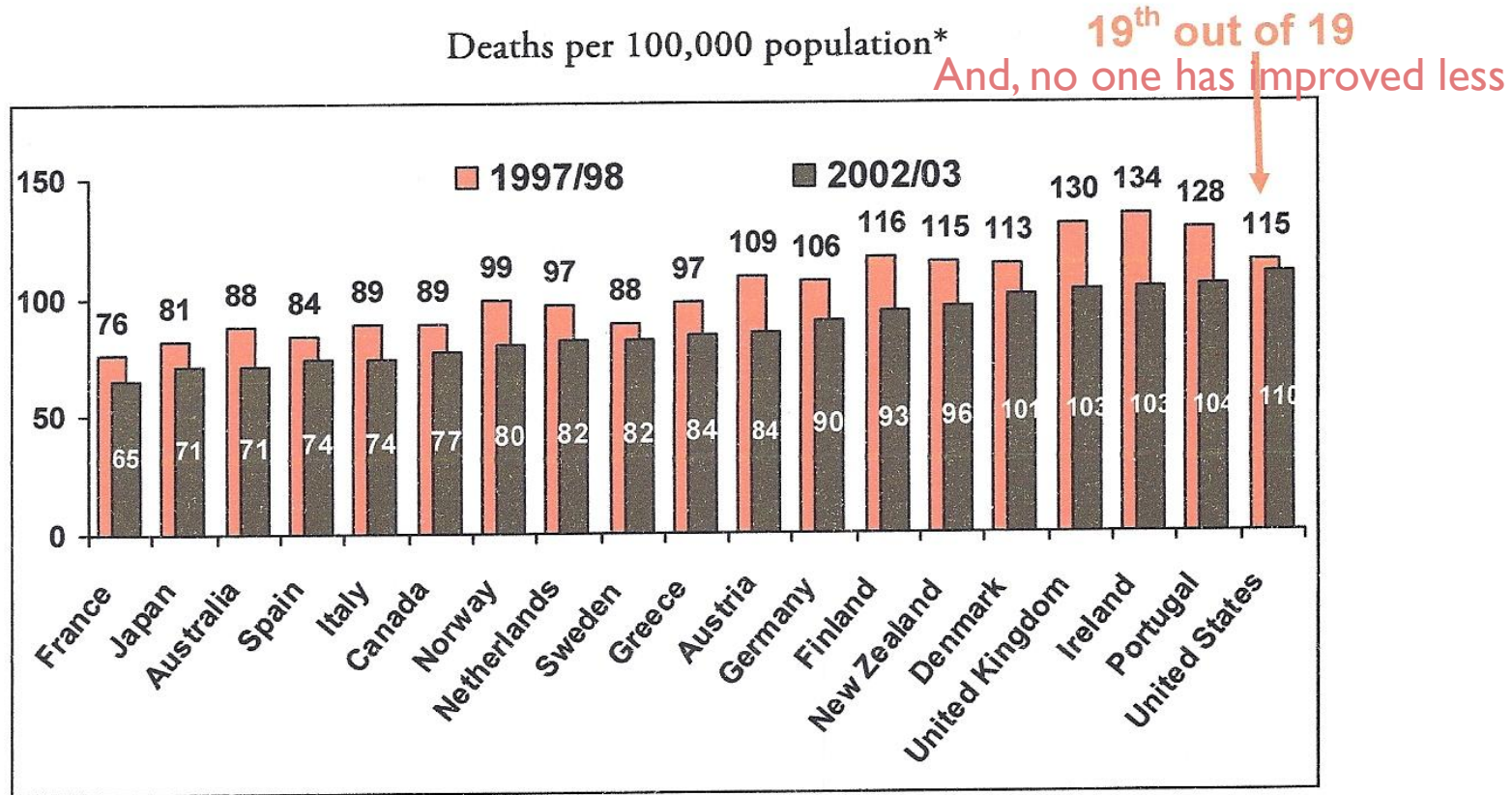
DO NOT BEND the cost curve, **BREAK** it

Average spending on health per capita (\$US PPP*)



* PPP = Purchasing Power Parity. Data: OECD Health Data 2008, June 2008 ⁵

Re-engineering care is not enough



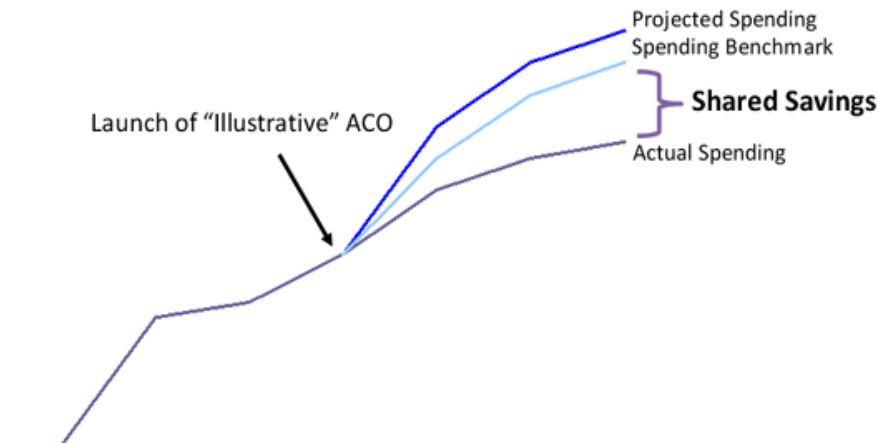
* Countries' age-standardized death rates before age 75; including ischemic heart disease, diabetes, stroke, and bacterial infections.

Data: E. Nolte and C. M. McKee, London School of Hygiene and Tropical Medicine analysis of World Health Organization mortality files (Nolte and McKee, *Health Affairs* 2008).⁶

Medicare's *Shared Savings Program (SSP)*

- Established by PPACA (§3022 modified by §10307)
- A program, not a demonstration project
 - No competition to participate
 - No deadline
 - Commencement: January 1, 2012
- A Bonus-Only model, although more advanced CINs may participate on a Population-Based Payment basis (§10307)

The Shared Savings conceptual model



- A 1 to 3 year period (likely 3) forms the base for projecting spending from which a target or benchmark will be established and against which project year spending will be measured to calculate savings available for sharing
- A corridor (2% in the PGP Demonstration) will be placed around the benchmark to provide for random variation
- The smaller the number of “attributed” beneficiaries the larger the corridor and the smaller the percentage of savings to be shared by the ACO
- MedPAC recognizes that physicians in higher spending areas have a greater incentives (a larger target) to change behavior and reduce unnecessary procedures
- A common market basket adjustment will level the playing field as costs are worked out of the system and the benchmark is lowered

Participation criteria

Limited to “Accountable Care Organizations” that...

1. Are willing to be **accountable for quality, cost** and care of a population of Medicare beneficiaries;
2. Will participate for not less than **3 years**;
3. Have a **legal structure** that can receive and **distribute bundled shared savings** payments;
4. Demonstrates enough primary care physicians are included to total a combined **Medicare patient population of at least 5,000**;
5. Has leadership and management and clinical and administrative management systems in place;
6. Promotes evidence-based medicine, report quality and cost measures and coordinate care including the use of technological systems; and
7. Demonstrates patient-centeredness

Dartmouth
could define
only 1,736

ACOs must achieve quality targets to receive distribution

Rule making expected soon. Based on PGP ...

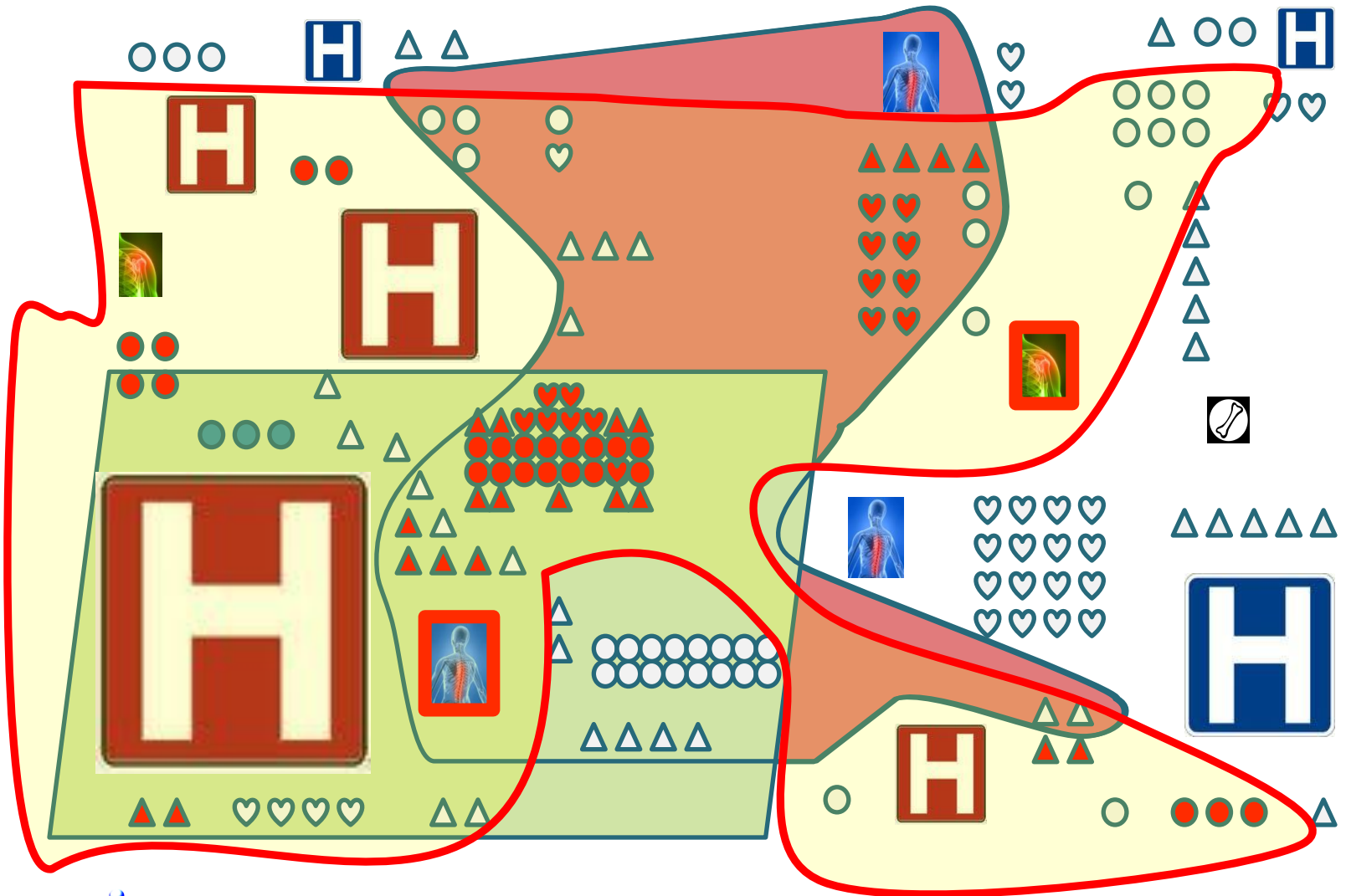
- Quality targets, phased in, will likely be ACO-specific based on experience or regional norms, adjusted over time by case mix changes.
- Every ACO will need to close the gap between its current level and CMS goals for each measure. This will likely be done incrementally with CMS establishing the interim, increasing targets.
- Outcome measures will likely be weighted more than process measures
- Partial attainment of quality goals may result in partial distribution. Or, there may be “core” measures which have to be met before any distribution.

The intent of accountable care is not to *achieve* quality but to *improve* it.

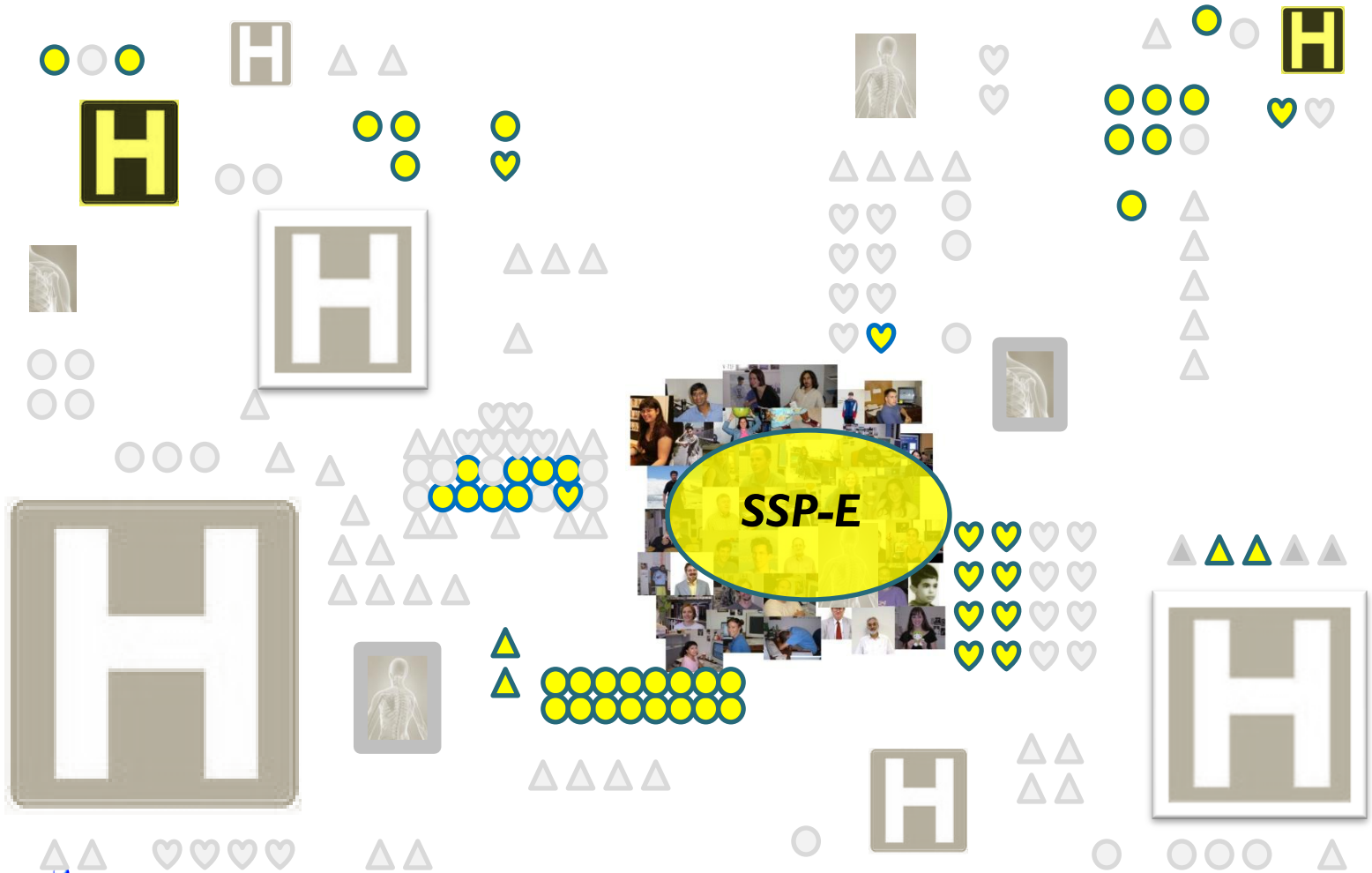
Unknown SSP variables

- Attribution model
- Definition of *primary care*
- Savings split
- Quality variables and targets
- Administration costs
- Preference weights (e.g., EMR, PCRI, private payer experience, soft variables, etc.)

The *PHO* and the *IPA* and the System *ACO*



Accountable care as conceived (Appropriate for the Shared Savings Program)



The answers

from various structural perspectives

Structure

Cost answer

Quality answer

Payers:

“Do it for less”

“Meet our targets”

Integrated Systems:

“Do it for less than yesterday”

“Use our targets”

IPAs and PHOs

“Do it for less than the competition”

“What targets?”

PCMH

“Just do it”

“Use targets”

ACO

“Do less of it”

“We’ll refer to the ones with the best outcomes”

Breaking the rules *for accountability's sake*

Integration rules to be broken The New Rules of Accountability

- | | |
|---------------------------------------|--|
| 1. More is better | Less, much less is necessary |
| 2. Patient-oriented | Population health-focused |
| 3. Process improvement | Process elimination |
| 4. Primary care secondary | Primary care primary |
| 5. Protect & grow volume | Plow under capacity |
| 6. Employ physicians | Restore and rely on the profession |
| 7. Joint venture revenue centers | Joint venture cost centers |
| 8. Egalitarian or equalitarian values | Elitist values |
| 9. Quality = least outcome defects | Quality = population health status |
| 10. Fiduciary responsibility trumps | Community health responsibility trumps |



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1. A copy of this Presentation
2. "Becoming Accountable," Strategic Financial Planning, HFMA, July 2010
3. "ACOs: Preparing for Medicare's Shared Savings Program," hfm, HFMA, August 2010