UNITED STATES HEALTH CARE REFORM: EARLY LESSONS FROM ACCOUNTABLE CARE ORGANIZATIONS

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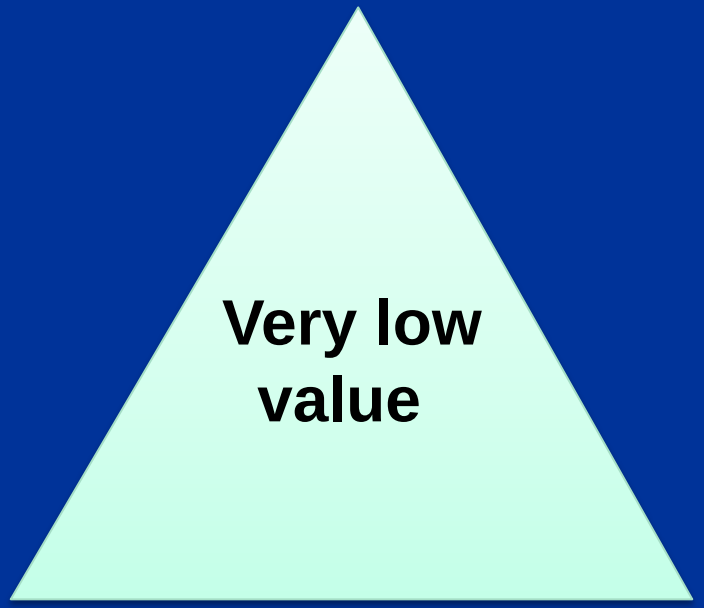
United States Health Care System Up to the Present Time

Quality
Highly Variable



Access
50 million plus uninsured

Cost
18 percent GDP
Most expensive

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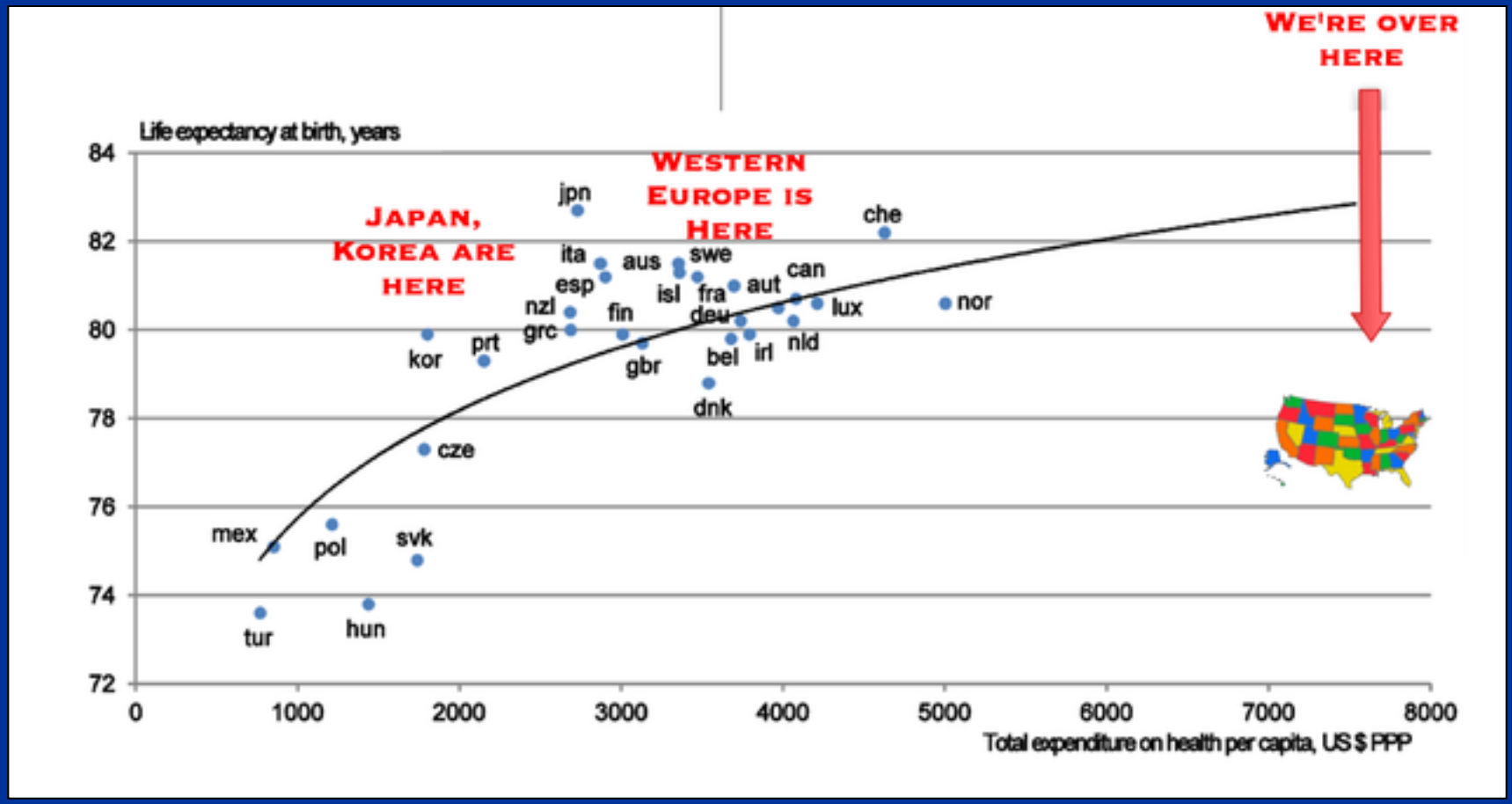

Source: OECD Health, June, 2011

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United States Health Care Aspirations – 2014 and Beyond

Quality
???

Access
Expanded insurance coverage for 32 million more Americans

Cost
???

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Key Questions

Will the increased insurance coverage be affordable in the long run?

Can the rate of increase in costs be contained?

Will require both payment reform and delivery system reform

The co-evolution of the two

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Key Idea

The ability to manage risk

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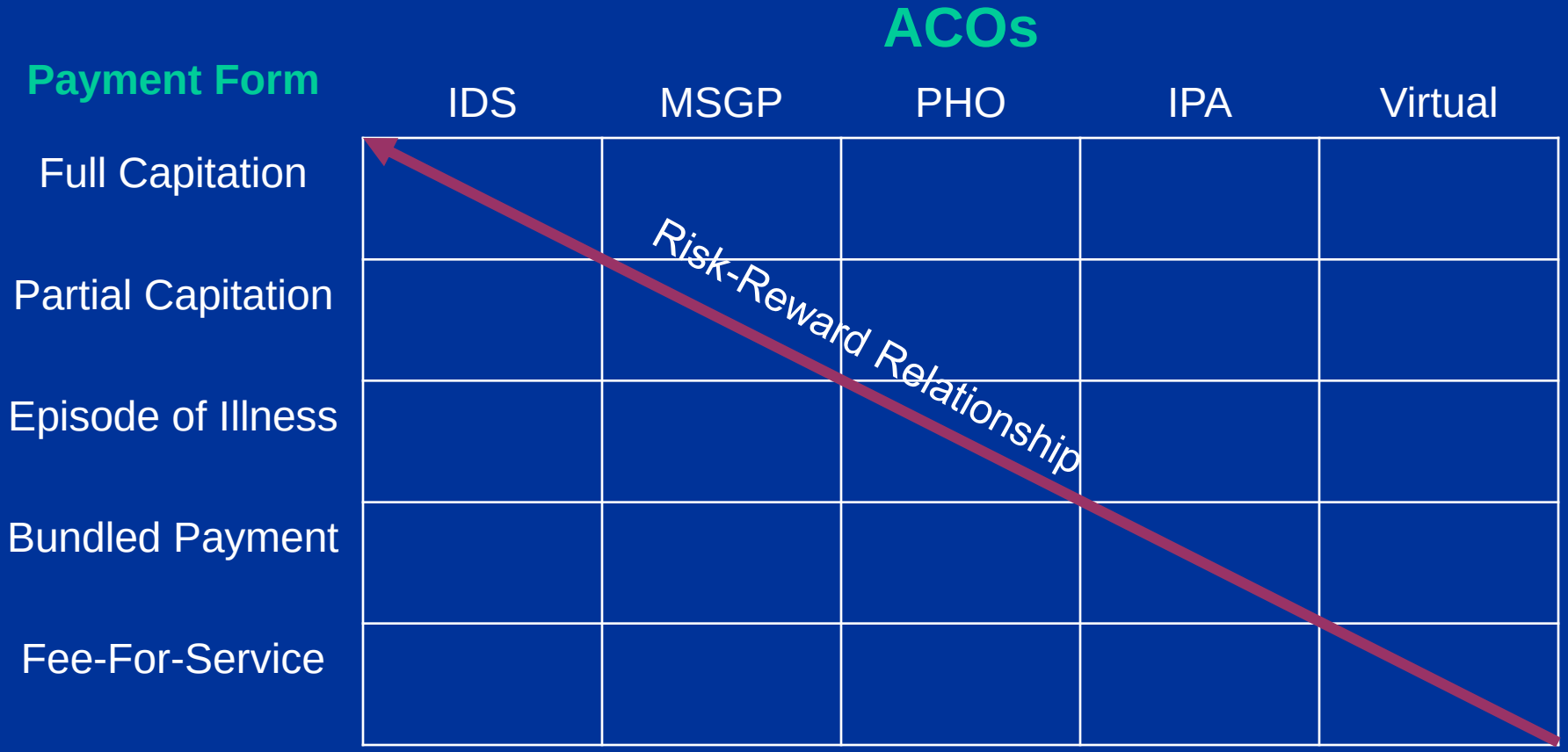
Ability to Manage Risk



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Accountable Care Organizations

Groups of physicians, hospitals, and other provider organizations that come together to be held accountable for both the overall cost and quality of care for a defined population of patients within a pre-determined expenditure target

ACO Tally Sheet

- 30 Pioneer ACOs
- 333 MSSP ACOs
- 116 are advanced payment
- 424 total ACOs in 48 states

People Live in Areas Where ACOs Are Available

- In 19 states, more than 50 percent of residents have access to ACOs
- In 12 states, between 25 and 50 percent of residents have access to ACOs (includes Montana)

Source: “The ACO Surprise” by Niyum Gandhi and Richard Weil. Oliver Wyman, Marsh, and McLennan Companies, 2012

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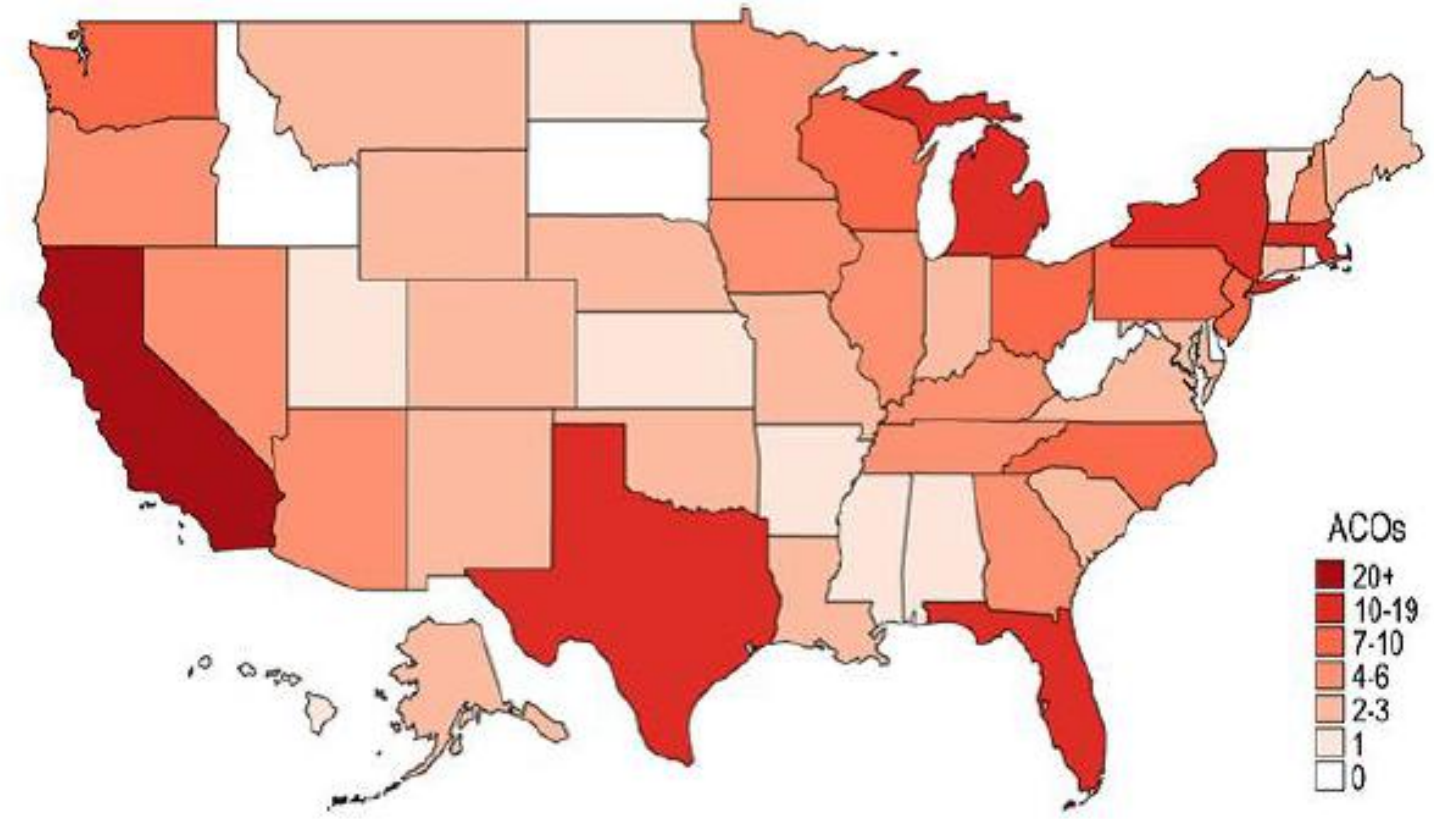
ACO Distribution by State



Source: David Muhlestein, Andrew Croshaw, Tom Merrill, Cristian Pena. "Growth and Dispersion of Accountable Care Organizations: June 2012 Update." Leavitt Partners. Accessed August 20, 2012 from LeavittPartners.com

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Some Key Issues

- Enrollment size matters – achieve sufficient savings to spread overhead and related costs
- Care management is key:
  - 5/50 stratification
  - Multiple chronic illness, frail elderly, dual eligibles, mental illness

Some Key Issues (cont'd)

- Building new relationships
  - Business model changes most for hospitals
  - Integrating different professional/social identities
  - Collaborative governance
- New tools required:
  - Information exchange across the continuum
  - Predictive risk modeling

Some Key Issues (cont'd)

- Patient activation and engagement
- Agreeing on a common set of cost and quality measures and thresholds, across payer contracts

What is Needed?

A New Care Management Platform

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New Care Management Platform

- Reduce office visits
- Expand between-visit at-home care management
- Improve “hand-offs”
- Smoother “glide paths” to health recovery
- **Technology enabled within a foundation of continuous improvement.**

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Some Required Changes

- Inpatient Care Workflow and Redesign
- Care Transition Management
  - e.g. Coleman Care Transition Model
- Physician Referral Patterns
- Interoperable EHRs
- From Inpatient Margin to Total Care Margin

Early Lessons from Brookings-Dartmouth ACO Pilot Studies

Source: “Advancing Accountable Care: Insights from the Brookings-Dartmouth ACO Pilot Sites,” under review, *Health Affairs*, 2012

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Common Challenges:

- Developing the care management capabilities across the entire continuum
- Building trusting relationships with physicians, payers and other partners
- Navigating the legal and contractual relationships

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Common Elements Across All Four Sites:

- Electronic health record functionality
  - Disease registries
  - Data warehouses
  - Predictive modeling to identify high-risk patients
- High-risk patient complex care management programs
- Physician champions
- Mature quality improvement – Six Sigma, LEAN

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Facilitators of ACO Formation and System Transformation

Factor	Role and Importance
Facilitators of ACO Formation	
Facilitators of Executive Leadership and Strong Governance	Supports development of shared aims, prioritizes resources and removes obstacles to allow for transformational change
Strong Payer-Provider Relationship	Facilitates trust and recognition of shared aims to overcome challenges in developing the ACO infrastructure
Experience with Performance-Based Payment	Develops capability to bear risk, aligns financial incentives and drives performance

Source: “Advancing Accountable Health Care: Insights from the Brookings-Dartmouth ACO Pilot Sites,” August 2012

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Facilitators of ACO Formation and System Transformation (cont'd)

Factor	Role and Importance
Facilitators of System Transformation	
Robust Health Information Technology Infrastructure	Supports data collection and reporting to identify waste, coordinate care, improve performance, and measure outcomes
Strong Care Management Capabilities	Provides tools and infrastructure to manage population health and improve care coordination
Performance Measurement and Transparency	Improves population health, supports care coordination, eliminates waste, and ensures accountability
Effective Physician Engagement	Perpetuates awareness and support throughout the system and develops physician champions for the model

Source: "Advancing Accountable Health Care: Insights from the Brookings-Dartmouth ACO Pilot Sites," August 2012

Early ACO Governance Key Lessons

- Shared goals and incentives
  - Directly linked to performance criteria and individual physician objectives
  - Based on value rather than volume
  - More difficult for hospitals who are not exclusive to specific ACO
- Governance model should reflect function
  - Long history – more formal and integrated
  - Shorter history – more reliance placed on managerial interaction
  - Need to first establish a culture of trust and supportive decision-making processes
  - Need structures that accommodate flexibility

Early ACO Governance Key Lessons (cont'd)

- Align measures and thresholds across payers
  - Reduce the complexity and costs involved
- Credibility and transparency of data
  - Risk-modeling tools for presenting comparative data help
  - Promote physician sense of interdependency for achieving ACO goals

Source: R. Addicott and S.M. Shortell, "Collaborative Governance Through Accountable Care Organizations: Recommendations for Policy and Practice." UC Berkeley School of Public Health, October, 2012

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Are ACOs More Than a Guess?

Some emerging evidence

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Medicare Physician Group Practice Demonstration

- Annual savings per beneficiary/year were modest overall
- But significant for dual eligible population – over $500 per beneficiary, per year
- Improvement on nearly all of 32 quality of care measures

Source: CH Colla, DE Wennberg, E. Meara, et al. “Spending Differences Associated with the Medicare Physician Group Practice Demonstration.” JAMA, September 12, 2012, 308 (10) 1015-23.

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Preliminary Results of Massachusetts Alternative Quality Contract (AQC)

- 2.8% lower costs ($90 per member, per year)
- Savings much larger among groups with no prior experience with risk sharing
- Savings largely from reduced spending for procedures, imaging, and lab tests
- Greatest savings come from patients with highest health risks
- 10 of 11 participating physician groups spent below their targets, earning a budget surplus payment. All earned a quality bonus.

Source: Karen Davis, Commonwealth Fund, July 21, 2012

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Comparison of Accountable Physician Practices Versus Other Practices

	Crude measures			Adjusted measures	
Quality Measures	**U.S**	**CAPP**	**Non-CAPP**	**Relative risk ratio**	**Relative risk ratio**
Mammography in women ages 65-69	50.4%	57.9%	53.1%	1.11	1.12
Completion of all three diabetic tests	53.9%	63.4%	57.1%	1.12	1.15
ACS admission rate; rate per 100	8.3	6.9	8.4	0.82	0.92
Cost Measures	**U.S**	**CAPP**	**Non-CAPP**	**Relative risk ratio**	**CAPP-non-CAPP difference**
Standardized MD in 2005	$2,881	$2,764	$3,003	-$239	-$176
Standardized hospital spending in 2005	$2,405	$2,193	$2,428	-$235	-$103
Total standardized CMS payments in 2005	$7,406	$7,053	$7,593	-$540	-$272

Source: Weeks WB, Gottlieb DJ, Nyweide, DJ, et al. "Higher Health Care Quality and Bigger Savings Found at Large Multispecialty Medical Groups," Health Affairs. May 10, 2010, 29(5): 991-997

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Early Evidence from Primary Care Medical Home Interventions

Group Health Cooperative of Puget Sound (Seattle, Washington)

- 29 percent reduction in ER visits; 11% reduction ambulatory sensitive admissions

Health Partners (Minnesota)

- 39% decrease ED visits; 24% decrease hospital admissions

Geisinger Health System (Pennsylvania)

- 18 percent reduction in all-cause hospital admissions; 36% lower readmissions
- 7 percent total medical cost savings

Source: Karen Davis, Commonwealth Fund, July 21, 2012

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Early Evidence from Primary Care Medical Home Interventions (cont'd)

Mass General High-Cost Medicare Chronic Care Demo (Massachusetts)

- 20 percent lower hospital admissions; 25% lower ED uses
- Mortality decline: 16 percent compared to 20% in control group
- 4.7% net savings annual

Intermountain Healthcare (Utah)

- Lower mortality; 5% relative reduction in hospitalization
- *Highest $ savings for high-risk patients*

Source: Karen Davis, Commonwealth Fund, July 21, 2012

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Sacramento Blue Shield: Dignity-Hill-Calpers Experience

- 42,000 Calpers Members
- Set target premium first – no increase in 2010– and then worked backward to achieve it
- Saved $20 million -- $5 million more than target, while meeting quality metrics
- Package of interventions:

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Sacramento Blue Shield: Dignity-Hill-Calpers Experience (cont'd)

- Package of interventions:
  - Integrated discharge planning
  - Care transitions and patient engagement
  - Created a health information exchange
  - Found that top 5,000 members accounted for 75% of spending
  - Evidence-based variance reduction
  - Visible dashboard of measures to track progress

Some Ideas to Promote "Spread"

- "Twinning" – organizational mentoring
- "Collaboratories" emphasizing customized technical assistance
- Clinical coaches (Rosenberg) – translate organizational goals to changes in individual physician behavior
  - Face-to-face and phone interaction with physicians
  - 25 MD's per MD coach
  - Targeted to helping individual physicians achieve quality and cost metrics

Summary

Health care reform in the United States will be slow and ongoing

BUT important changes are occurring

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Thank You
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