Workhorse or Unicorn: Incentive Realignment and Health Improvement After One Year of ACOs

By James E. Orlikoff and Len Nichols

Objectives

- Explain the concept of the ACO in theory and in practice
- Discuss the various types of ACOs in the market and how they are performing
- Identify the challenges in creating a functional ACO
Which Animal Best Describes an ACO?

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An Accident of History: ACO’s Were Designed after the “Group Practice Demonstration Project”

- This was a seriously flawed experiment
- Hitting the “spending reduction targets” had more to do with **coding** than with actual cost reduction
- Only half the groups got any extra payments
- Groups who were already low in cost simply worked hard, made quality better, and got nothing.

Achieving quality goals had little to do with getting shared savings payments

<table>
<thead>
<tr>
<th>Physician Group Practice</th>
<th>Percentage of Quality Goals Attained</th>
<th>Shared Savings Payments ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Year 1</td>
<td>Year 2</td>
</tr>
<tr>
<td>Billings Clinic, Billings, MT</td>
<td>90.91</td>
<td>97.78</td>
</tr>
<tr>
<td>Dartmouth-Hitchcock Clinic, Lebanon, NH</td>
<td>95.45</td>
<td>97.78</td>
</tr>
<tr>
<td>Everett Clinic, Everett, WA</td>
<td>86.36</td>
<td>95.56</td>
</tr>
<tr>
<td>Forsyth Medical Group, Winston-Salem, NC</td>
<td>100.00</td>
<td>100.00</td>
</tr>
<tr>
<td>Geisinger Clinic, Danville, PA</td>
<td>72.73</td>
<td>100.00</td>
</tr>
<tr>
<td>Marshfield Clinic, Marshfield, WI</td>
<td>81.82</td>
<td>100.00</td>
</tr>
<tr>
<td>Middlesex Health System, Middletown, CT</td>
<td>86.36</td>
<td>95.56</td>
</tr>
<tr>
<td>Park Nicollet Clinic, St. Louis Park, MN</td>
<td>95.45</td>
<td>97.78</td>
</tr>
<tr>
<td>St. John's Clinic, Springfield, MO</td>
<td>100.00</td>
<td>100.00</td>
</tr>
<tr>
<td>University of Michigan Faculty Group Practice, Ann Arbor</td>
<td>95.45</td>
<td>100.00</td>
</tr>
</tbody>
</table>

*Because the CMS applied different weights to each of the quality measures, the agency calculated the quality goals attained as percentages, rather than absolute numbers of measures. Data are from RTI International.

So Why Have ACOs Been Such A Hot Topic in Reform?

- Dartmouth Atlas showed that costs and quality could be attributed fairly accurately to the “community of practice” defined by hospital service areas, and that performance varies widely from one hospital community to another
  - McAllen v Grand Junction
  - Miami v Minneapolis
  - Los Angeles v Sacramento
- So....if cost and quality can be *attributed* to hospitals and their “extended medical staffs” perhaps they could be held *accountable*.
- And if they could be held accountable, and share in the savings from their lower costs, then many communities would somehow perform a lot like Geisinger, and Kaiser, and Mayo....*then a miracle would happen!*
A Brief History of ACOs

The term “Accountable Care Organization” (ACO) was coined by Elliott Fisher, Director of the Center for Health Policy Research at Dartmouth Medical School, in 2006 at a public meeting of the Medicare Payment Advisory Commission. The term and concept gained currency and was featured in the health reform law, the Patient Protection and Affordable Care Act in 2010. The ACO model builds on the Medicare Physician Group Practice Demonstration and the Medicare Health Care Quality Demonstration projects.
“Accountable care organizations (ACOs) are provider collaborations that integrate groups of physicians, hospitals, and other providers around the ability to receive share-saving bonuses by achieving measured quality targets, and demonstrating real reductions in overall spending growth for a defined population of patients. ACOs can be organized in a number of provider configurations with different payer participants. They can also feature different payment incentives ranging from “one-sided” share savings within a fee-for-service environment, to a range of limited or substantial capitation arrangements with quality bonuses.

Elliot Fisher’s Case for Hospital-Based ACOs

- Physicians are “assignable” by hospital
  - 62% of physicians do some hospital work
  - A given physician does 90% of his work at one hospital
- If the hospital-physician cluster were somehow held accountable for cost/quality of care, this “ACO” could theoretically control capacity.
- Hospitals have the management structures and capital resources to make the necessary investments in IT etc.

_Fisher et al., Creating Accountable Care Organizations: the Extended Hospital Medical Staff,
Health Affairs Web Exclusive, December 5, 2006 w44.w57_
Fisher and colleagues theorize that when you cap the total resources coming into a specific “community,” hospitals and physicians would form organizations to accept and manage the global payments. This would create an economically motivated community lobby for not building more hospital beds, not recruiting additional cardiologists, not putting CT scanners in physician offices. Little delegations from the ACO would visit the high utilizers and work with them to get them to give up their diagnostic equipment and reduce their incomes. (As Dave Barry would say, “I am not making this up.”)

ACO Defined

According to CMS, an ACO is “an organization of health care providers that agrees to be accountable for the quality, cost, and overall care of Medicare beneficiaries who are enrolled in the traditional fee-for-service program who are assigned to it.”
ACO Defined

An ACO is a healthcare organization characterized by a payment and care delivery model that seeks to tie provider reimbursements to quality metrics and reductions in the total cost of care for an assigned population of patients. A group of health care providers, acting in a coordinated or integrated way forms the ACO which then provides care to a group of patients. The ACO may use a range of payment models such as bundled payments; capitation; fee-for-service with asymmetric or symmetric shared savings; and others.

ACO Defined

The ACO is “accountable” to the patients and the third-party payer for the quality, appropriateness and efficiency of healthcare provided.
ACO Defined: Three Core Principles

While the ACO model is designed to be flexible, and there are many different forms, three core principles exist:

1. Provider-led organizations with a strong primary care base that are collectively accountable for quality and total per capita costs across the full continuum of care for a population of patients.

2. Payments are tied to quality and improvements in quality that also reduce overall costs.

3. Reliable and progressively more sophisticated performance measurement, to support continuous improvement and actual achievement of savings through improvements in care.
MODELS OF ACOs

Medicare offers several ACO Programs, including:
1. Medicare Shared Savings Program (MSSP)
2. Pioneer ACO Model
3. Advance Payment Model
There appear to be at least 8 different payment models in play, with other variations in the private sector.

Medicare Shared Savings Model

Designed to Promote Accountability for the Care of Medicare FFS beneficiaries;
Requires Coordinated Care for all Services Provided Under Medicare FFS
Encourages Investment in Infrastructure and Redesigned Care Processes
Will Reward ACOs that lower growth in health costs while meeting performance standards on quality.
Medicare Shared Savings Model

Two Payment Models: One-Sided (asymmetric); and Two-Sided (Symmetric).

One-Sided **Original Plan**: ACOs Get Shared Savings for the First Two Years, Then Assume Shared Losses in Addition to the Shared Savings for the Third Year.

Two-Sided **Original Plan**: ACOs Participate in Both Shared Savings and Losses for All Three Years.

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Medicare Shared Savings Model

**Original Plan**: Although the ACO Assumes Less Financial Risk in the One-Sided Model, ACOs Have a Maximum Sharing Rate of 50% in the One-Sided Model and a 60% Max in the Two-Sided Model, Provided that the Minimum Shared Savings Rate Threshold of 2% is Reached. For Both Models there is a Shared Loss Cap that Increases Each Year.
Medicare Shared Savings Model

**Revised Plan** Due to Concerns from the Field, DHHS Final Regs (Oct 20, 2011) Altered Providers’ Financial Incentives. One-Sided Model no Longer Has Any Financial Risk Throughout the Three Years, But Continued to Have Opportunity to Share in Cost Savings Above 2%. Two-Sided Model: Assume Some Financial Risk But Can Share in ANY Savings that Occur (No 2% Benchmark before Provider Savings Accrue)

Pioneer ACO Model

Designed for HC Organizations and Providers that are Already Experienced in Coordinating Care for Patients Across Care Settings. It will Allow These Groups to Move More Rapidly from a Shared Savings to a Population-Based Payment Model on a Consistent, but Separate Track from MSSP. It is Designed to Work in Coordination with Private Payers by Aligning Provider Incentives.
Pioneer ACO Model

Payments Being Tested in the First Two Years of the Pioneer ACO Model are a Shared Savings with Higher Levels of Both Shared Savings and Risk than Under MSSP. In Year Three of the Program, Pioneer ACOs that have Shown a Specified Level of Savings can Move a Substantial Portion of their Payments to a Population-Based Model with Full Risk that can Continue through an Optional 4th and 5th year.

Pioneer ACO Model

Includes Strong Patient Protections to Ensure Access and Quality. Pioneer ACOs will be Expected to Improve the Health and Experience of Care for Individuals, Improve the Health of Populations, and Reduce the Rate of Growth in HC Spending. Pioneer ACOs will be Financially Accountable for the Care Provided; CMS will Publicly Report Performance on Quality Metrics, Including Patient Experience Ratings, on its Website.
Advance Payment ACO Model

Designed to Help Smaller ACOs (Physician-Based and Rural Providers) with Less Access to Capital Participate in the Shared Savings Program. Provides an Upfront Fixed Payment; an Upfront Variable Payment Based on Number of Historically-Assigned Beneficiaries; A Monthly Payment Based on the Size of the ACO.

How Many ACOs? About 167

1. Medicare Shared Savings – 115
First cohort stated April 1, 2012 with 27; Second cohort began July 1, 2012 with 88.

2. Pioneer ACO Model – 32

3. Advance Payment ACO Model - 20
ACOs: Some Early Lessons and Questions

- Intense Focus on Cost and Cost Reduction
- Physicians Move to Laser-Like Focus on “My Results versus Peers”
- A Huge Interest in and Need for Data
- Physicians Have Been Willing to Make Difficult Decisions That Had Been Avoided in the Past
- Hospital Revenue Declines From:
  - Reduced ER Use; Reduced Admissions; Reduced Discretionary Diagnostics.
Jumping The Curve From:

“Eminence Based Medicine”
Making the same mistakes with increasing confidence over an impressive number of years.

~BMJ, Vol. 1 Sept 2001

“Evidence Based Medicine”
Rapidly integrating individual clinical expertise with the best available external clinical evidence from systematic research.

Nate Kaufman, Kaufman Strategic Advisors

Key Drivers of Costs for a Population

- Health status of the population
- Degree to which the population gets “all and only” the care that will help them
  - Evidence-based medicine (underuse)
  - Supply-induced demand (overuse)
- Prevention of “potentially avoidable complications” of care
- Patterns of care at end of life
- Forget the 80-20 Rule. You Live or Die on the 5-50 Rule!
If you’re **really** going to deliver high value health care for a population…

- You’ll probably have to know who’s in the population
- You’ll have to find some way to align provider incentives with your business model
- You’ll have to know how to standardize what is standardizable, reduce waste, and eliminate potentially avoidable complications
- You’ll have to control capacity, especially for overused services
Potentially Avoidable Complications: 
*Where a Lot of the Money Is*

**Diabetes Relevant Services**  
- Medical: $595 Million  
- Pharmacy: $732 Million  

**Potentially Avoidable Complications: $813 million**
- All diabetes-related inpatient stays
- All professional services during stays
- All claims with "PAC" diagnosis codes
- All claims with "PAC" procedure codes
- Drugs used to treat PACs

**Typical claims and services: $515 million**
- Medical: $108 Million
- Pharmacy: $407 Million
- Claims that do not have a "PAC" code

Care defects account for 20-75% of the costs for chronic diseases and common procedures

**Cost of care defects as % total cost of care for each condition/procedure**

- Cost range from 10% to 90%
These tasks, in aggregate, do not involve minor tinkering with your current organization. They require transformational changes.

ACOs: Implications

- To succeed in this game will require an unusual combination of
  - disparate organizations providing care across the continuum in a truly integrated way
  - great governance, executive, and clinical leadership
  - strong capital base
- Culture will be a major determining factor of success—likely more so than structure, technology, and even financial incentives
ACOs: Some Early Lessons and Questions

Anecdotal Reports:
- 45% of ACO Patients with a PCP Use at Least Some Services from a Competing Hospital
- 30% of Seniors Get Their Primary Care from a Sub-Specialist
- Looming Question: If Our ACO is Successful, How Will We Distribute the Savings?

Was Macbeth Talking About ACOs?

...but a walking shadow, a poor player
That struts and frets his hour upon the stage
And then is heard no more: it is a tale
Told by an idiot, full of sound and fury,
Signifying nothing.