

How to Create Accountable Care Organizations

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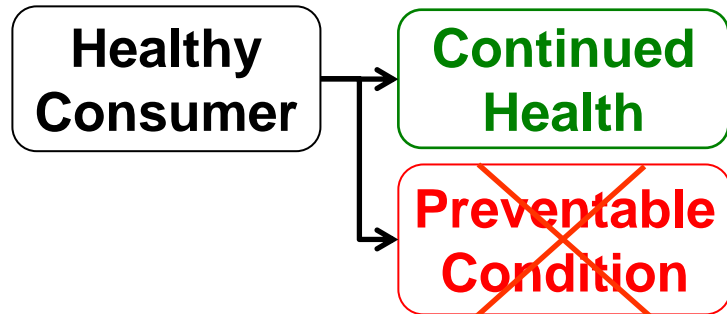
Network for Regional Healthcare Improvement

What's the Goal of “Accountable Care Organizations?”

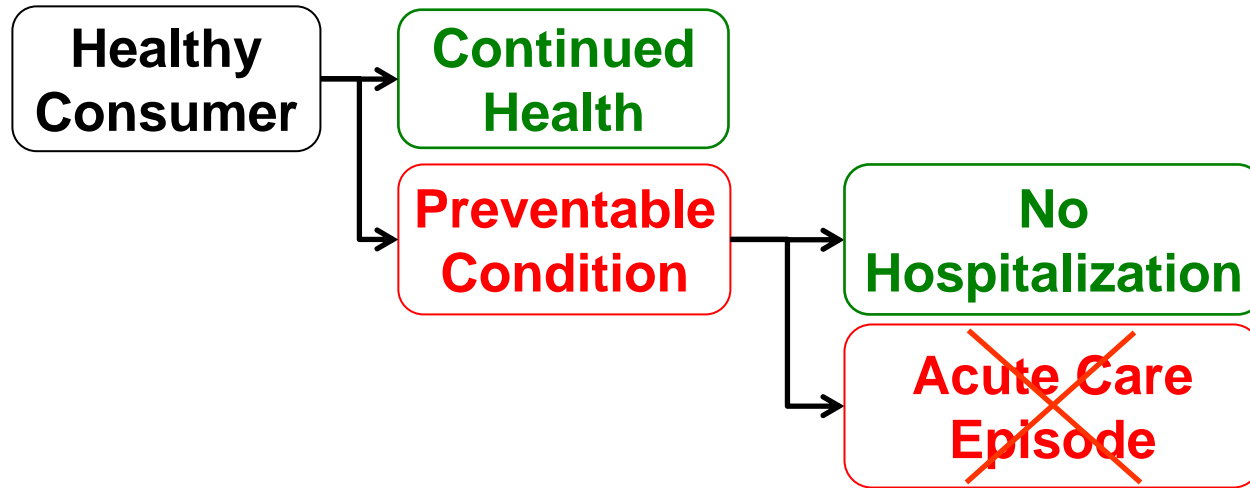
What's the Goal of “Accountable Care Organizations?”

Reducing Healthcare Costs Without Rationing

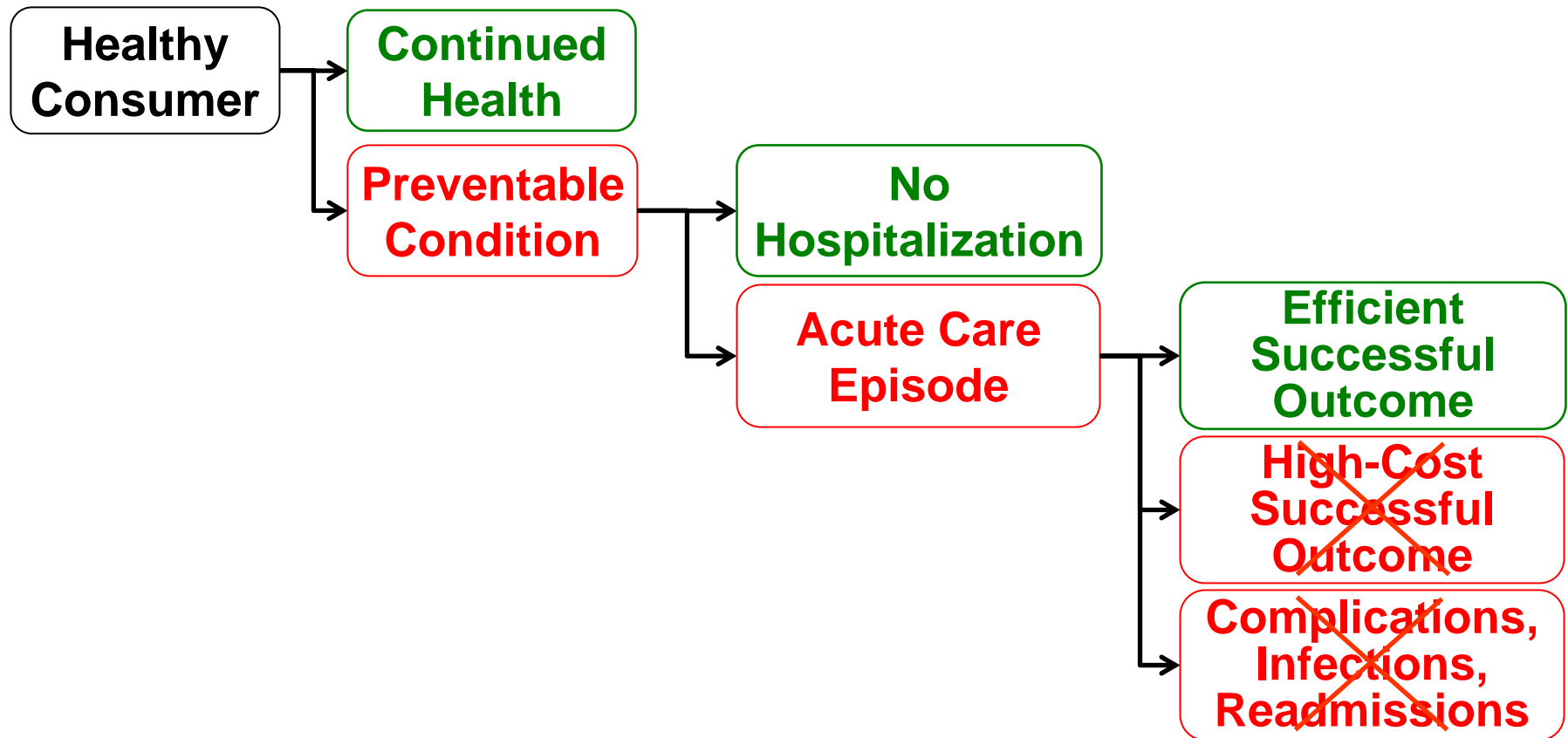
Reducing Costs Without Rationing: Prevention and Wellness



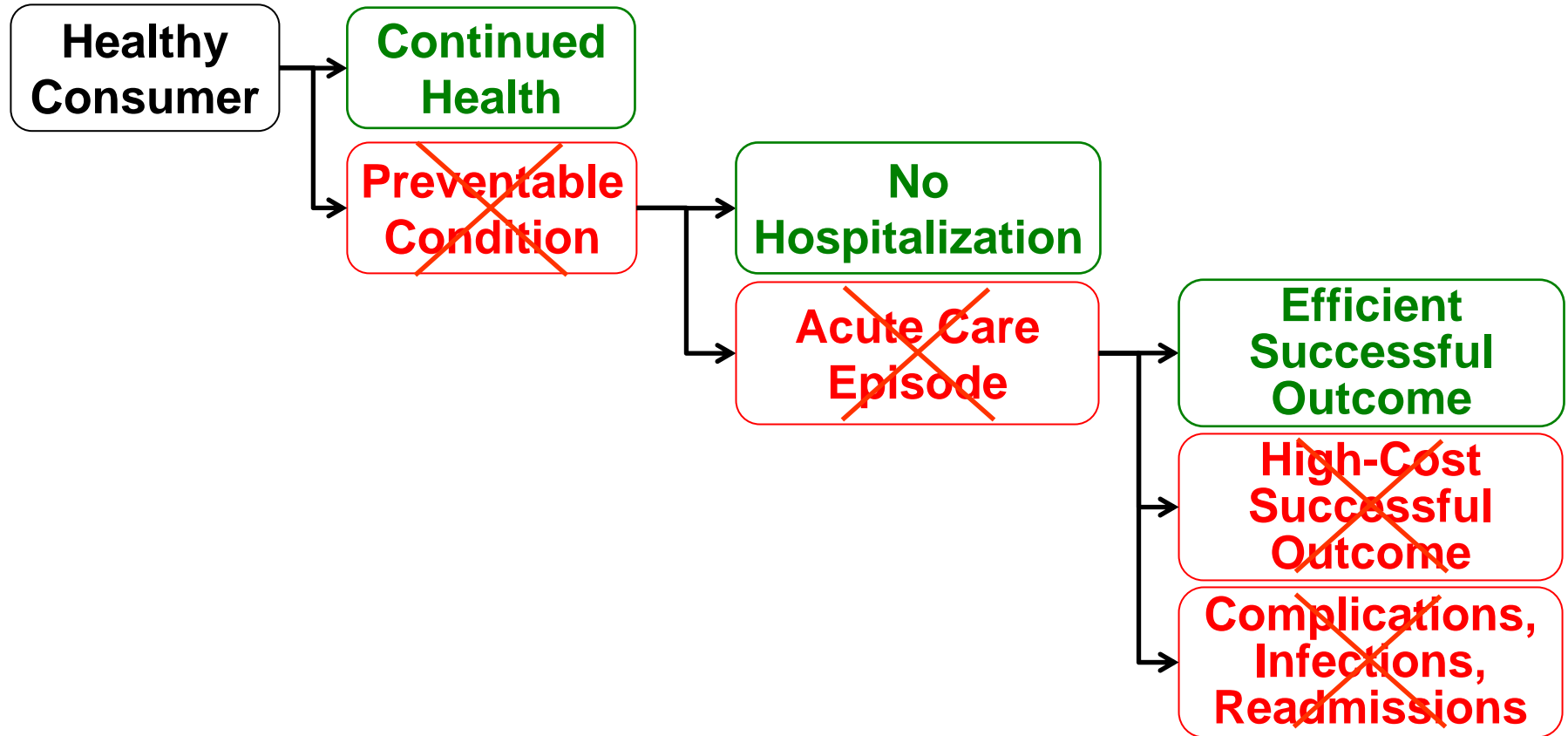
Reducing Costs Without Rationing: Avoiding Hospitalizations



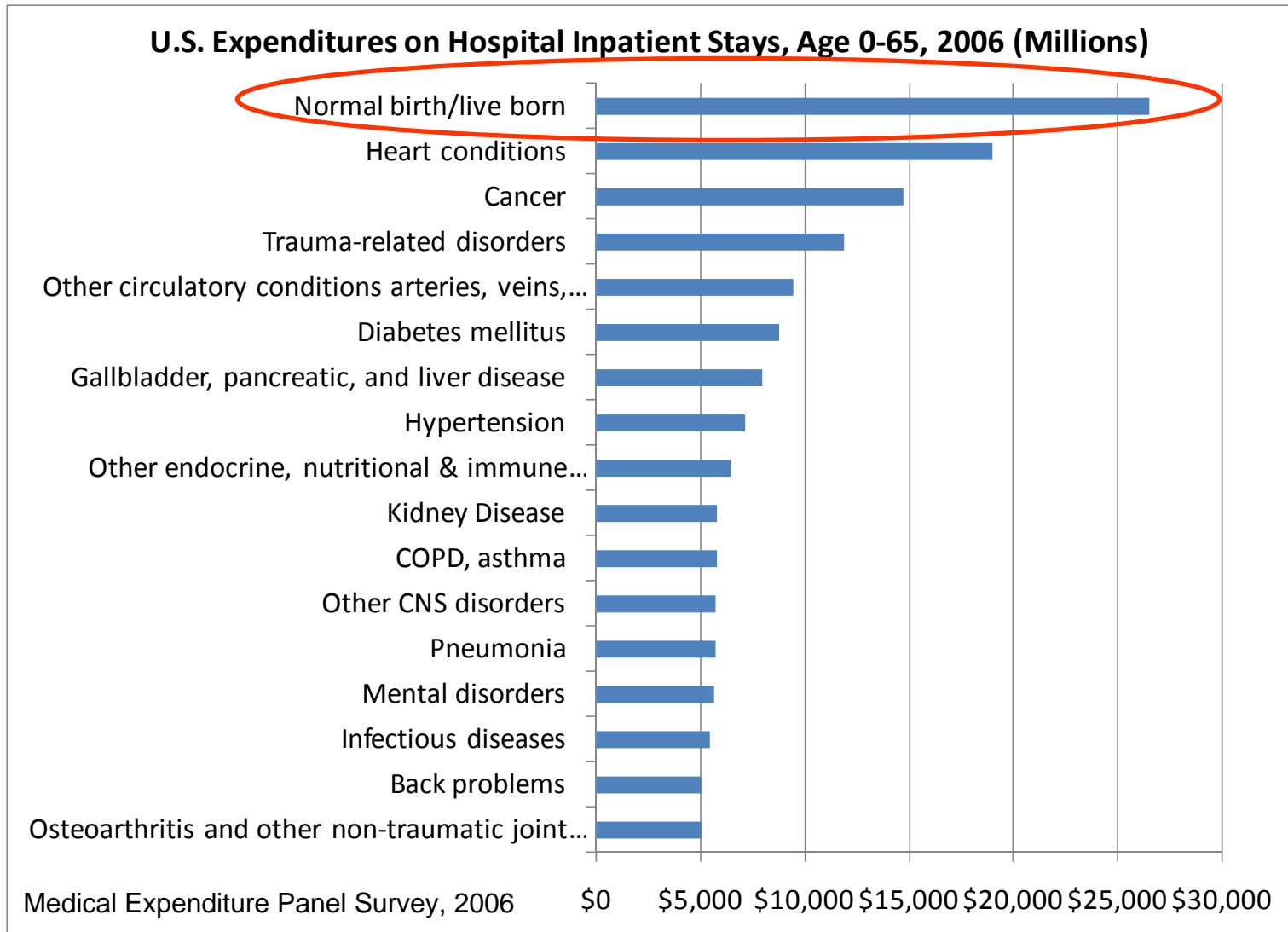
Reducing Costs Without Rationing: Efficient, Successful Treatment



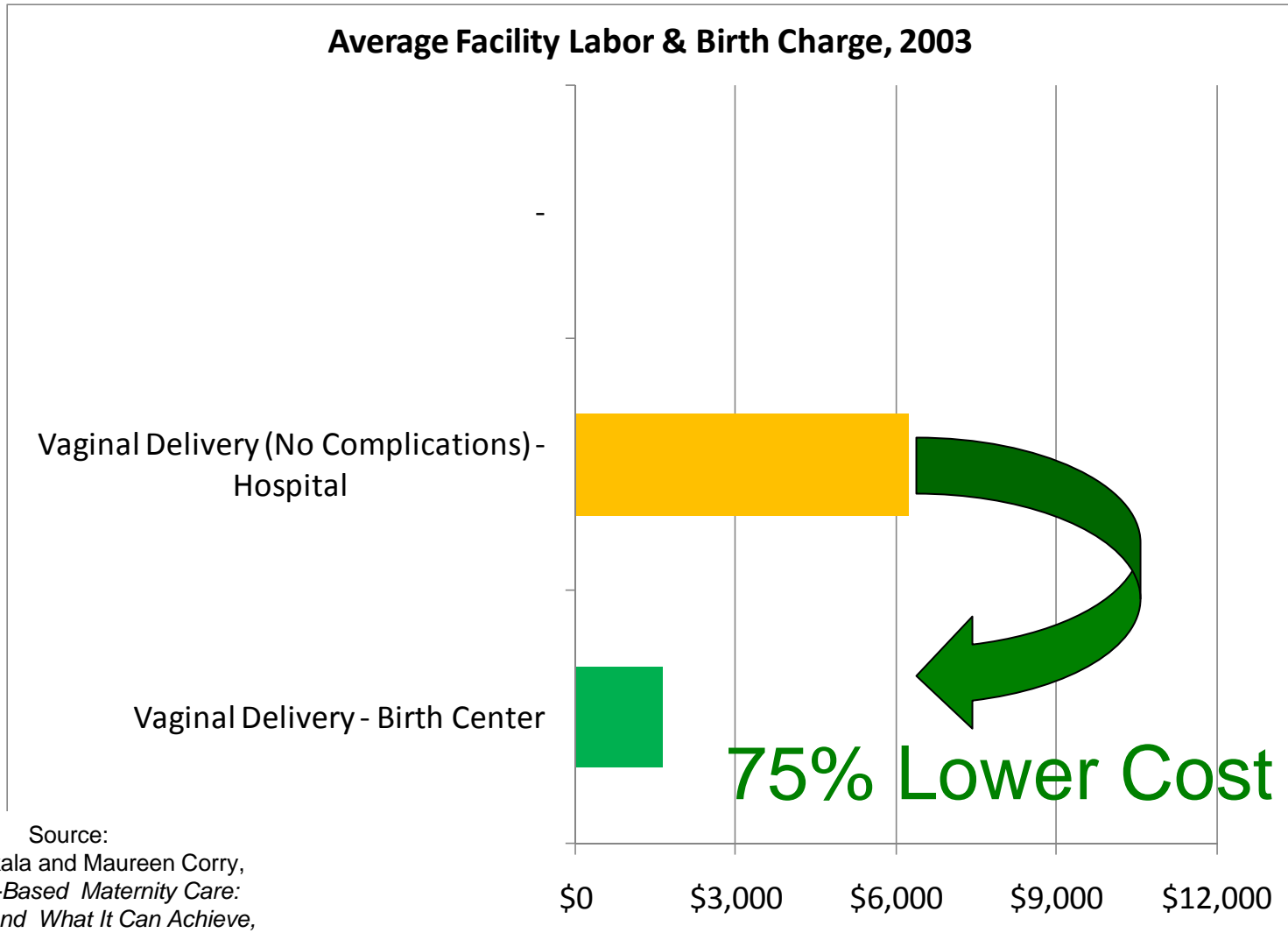
Reducing Costs Without Rationing Is Also Quality Improvement!



Go Where the Money Is: #1 = Maternity Care

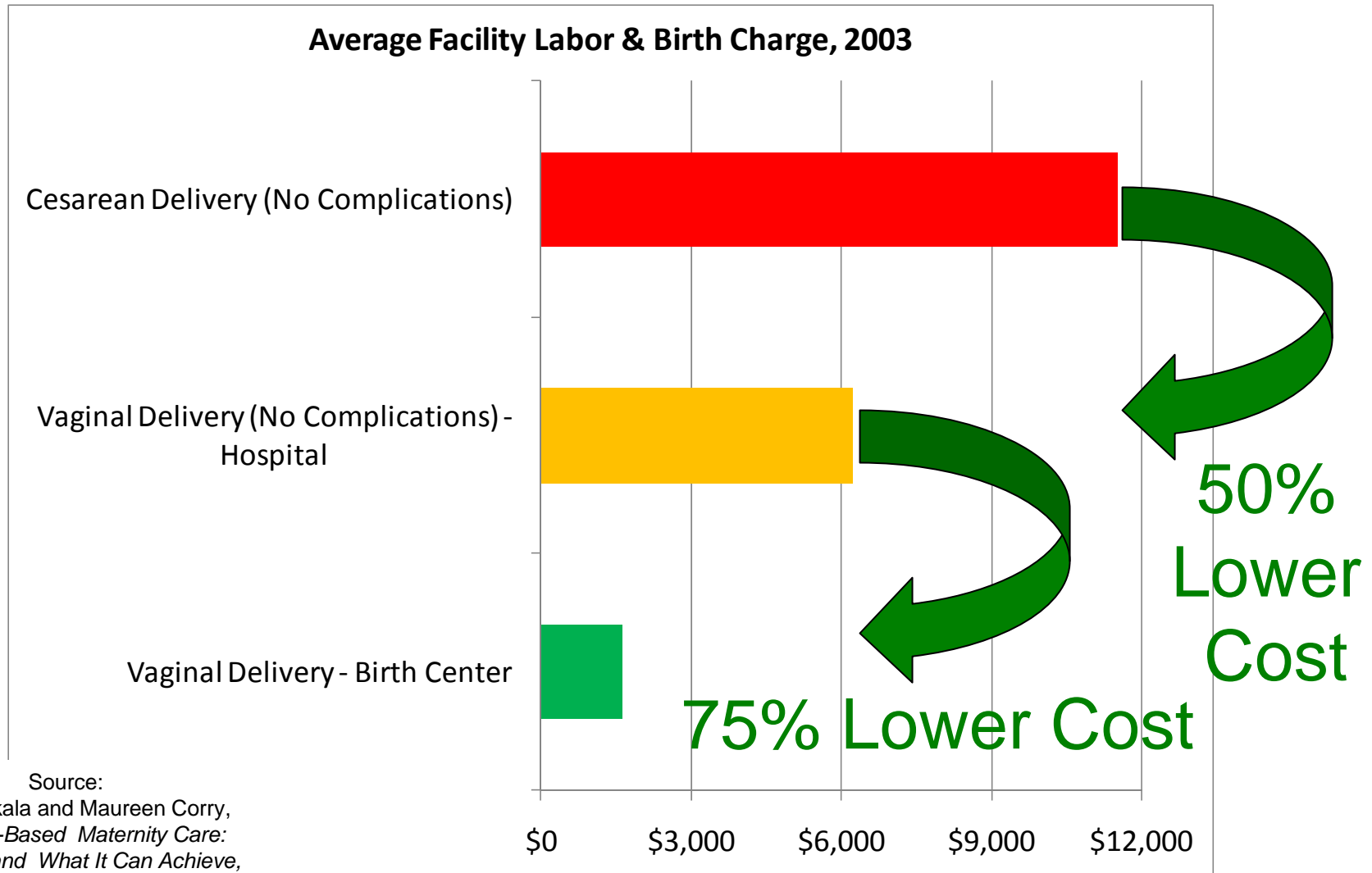


Maternity Care Costs Can Be Reduced By Using Birth Centers...

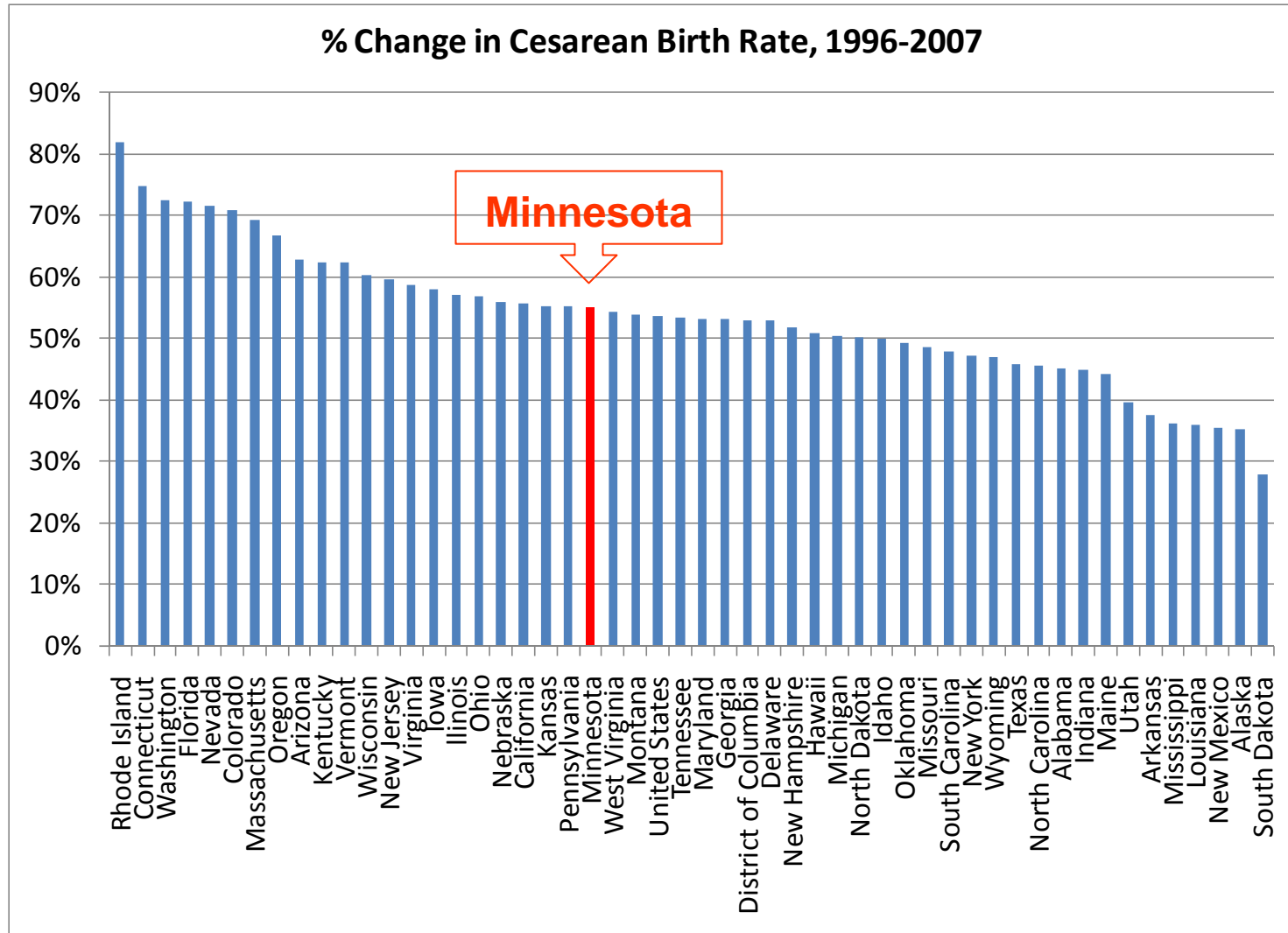


Source:
Carol Sakala and Maureen Corry,
*Evidence-Based Maternity Care:
What It Is and What It Can Achieve*,
Milbank Memorial Fund
2008

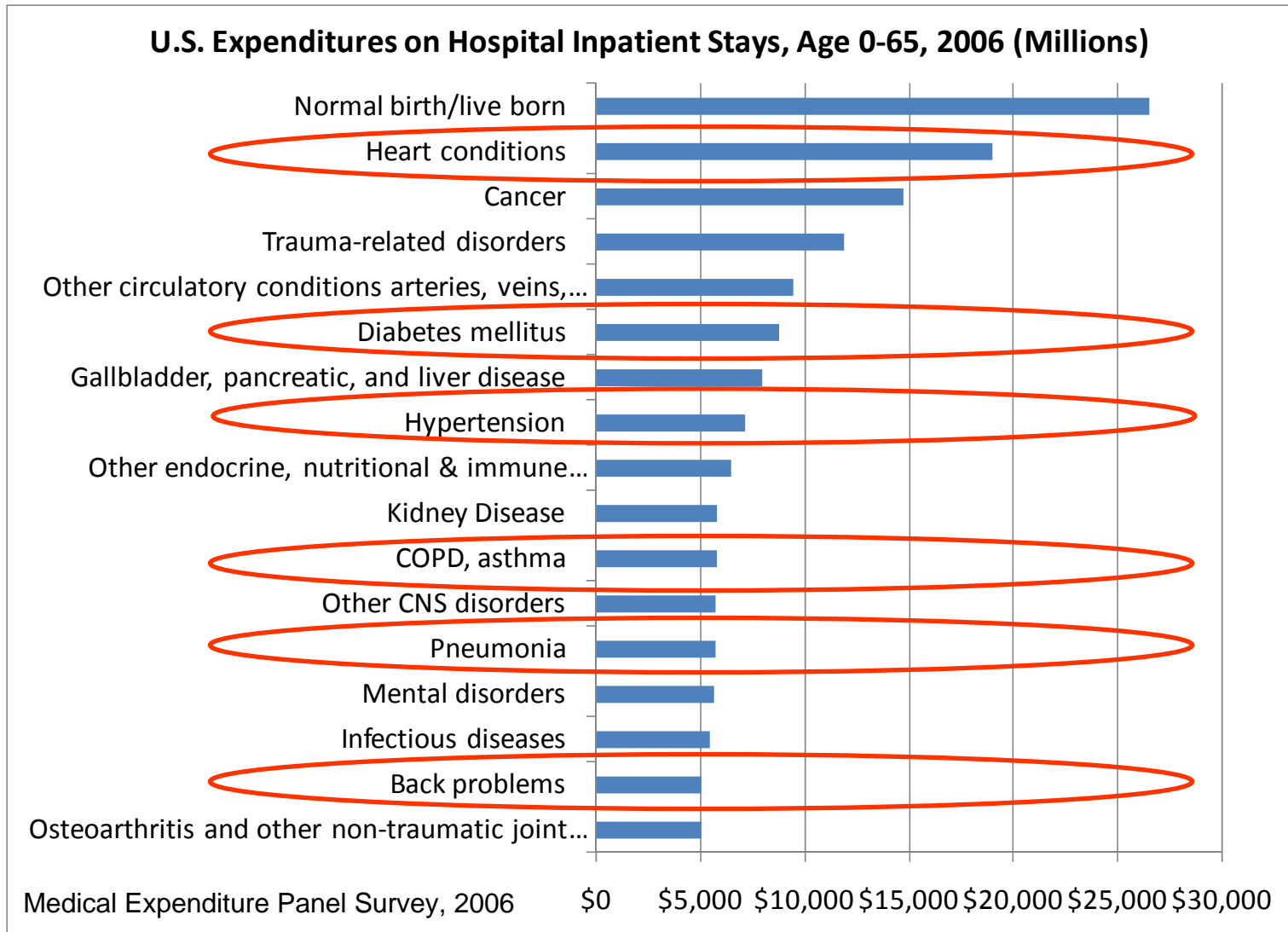
...And By Avoiding Unnecessary C-Sections



Above-Average Increase in C-Sections in Minnesota



Next in Line: “Ambulatory Care Sensitive Conditions”

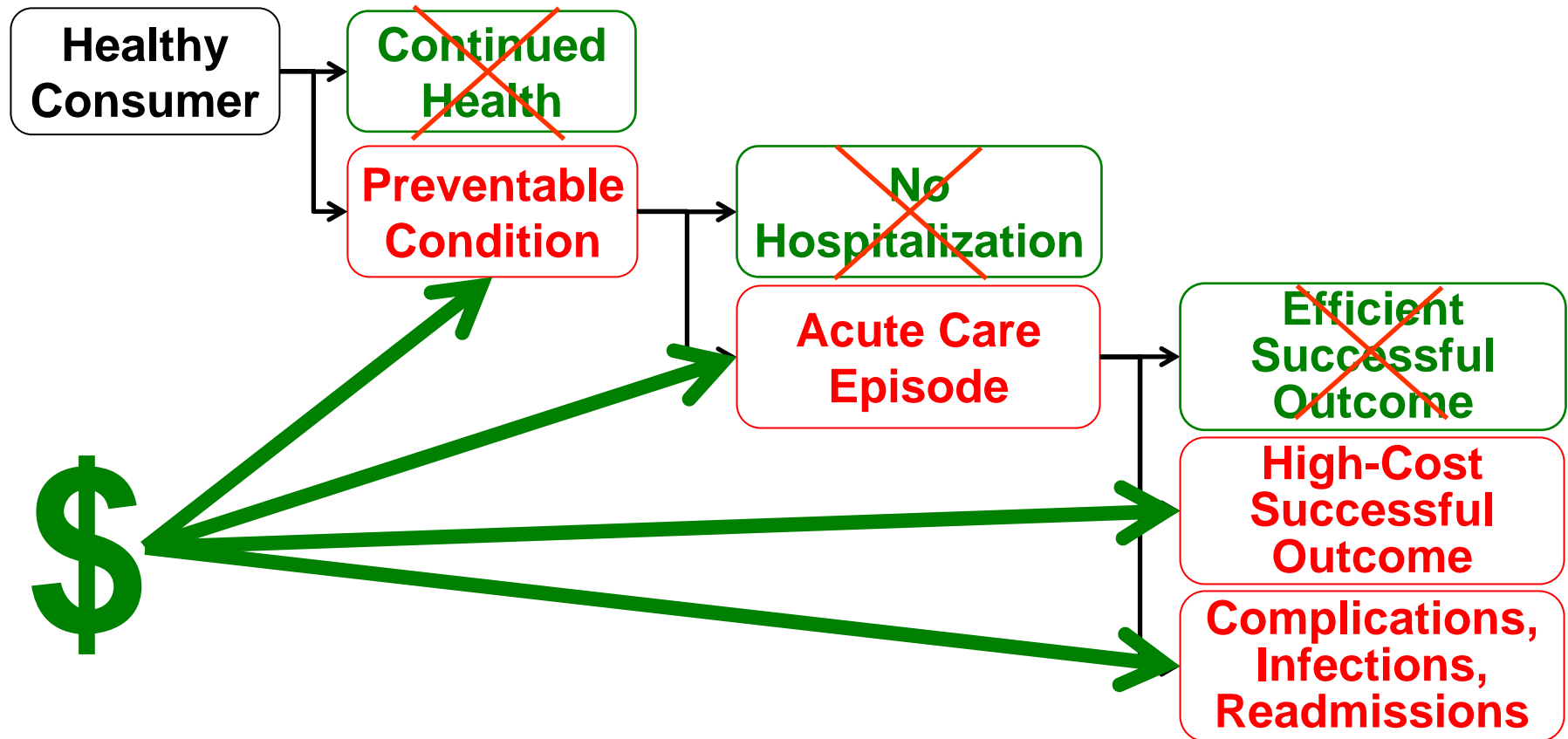


Dramatic Reductions in Rate of Hospitalizations Are Possible

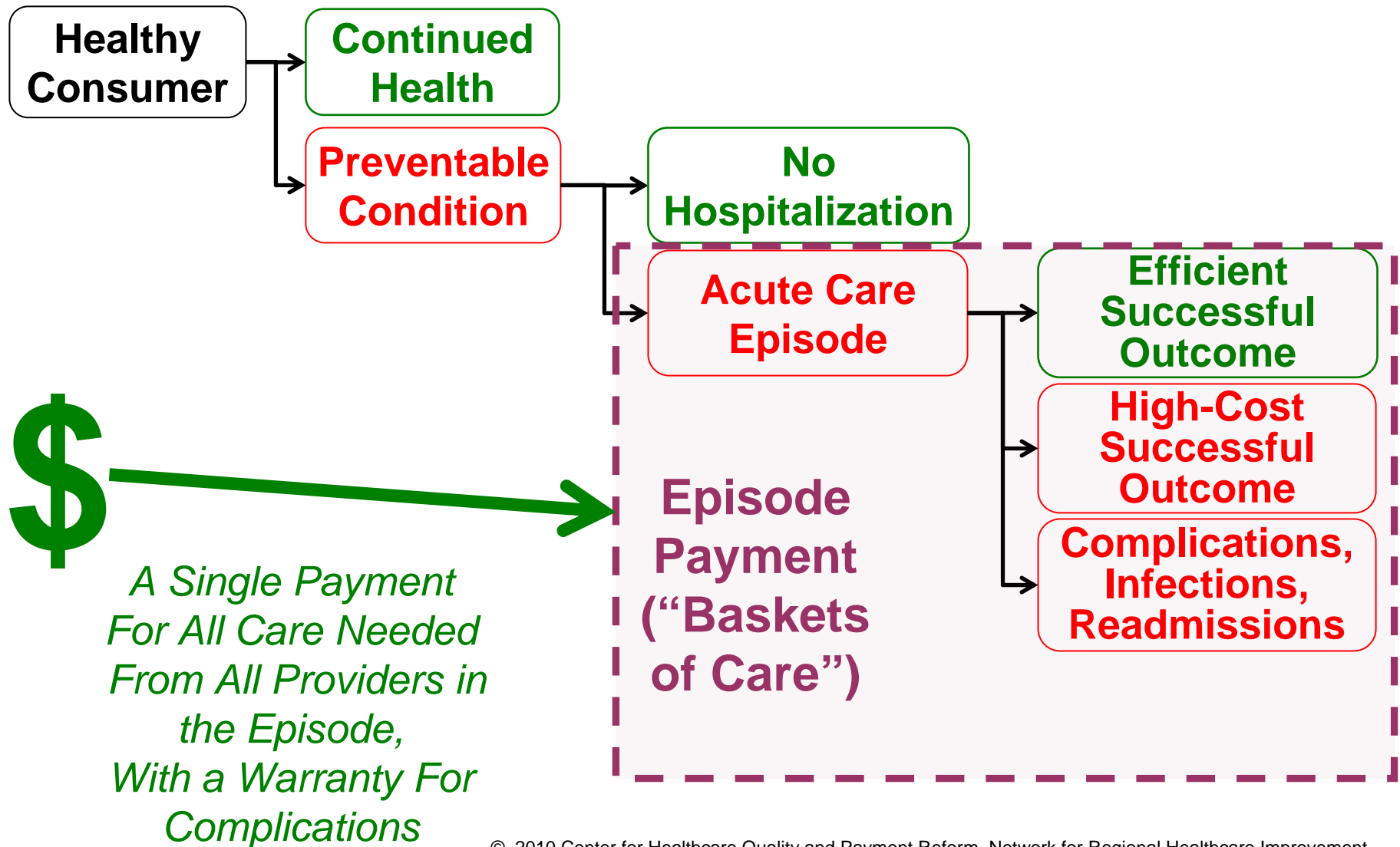
Examples:

- 40% reduction in hospital admissions, 41% reduction in ER visits for exacerbations of Chronic Obstructive Pulmonary Disease (COPD) using in-home & phone patient education by nurses or respiratory therapists
- 66% reduction in hospitalizations for Congestive Heart Failure patients using home-based telemonitoring
- 27% reduction in hospital admissions, 21% reduction in ER visits for Chronic Obstructive Pulmonary Disease (COPD) through self-management education

Current Payment Systems Reward Bad Outcomes, Not Better Health



“Episode Payments” to Reward Value *Within* Episodes



Yes, a Health Care Provider Can Offer a *Warranty*

Geisinger Health System ProvenCareSM

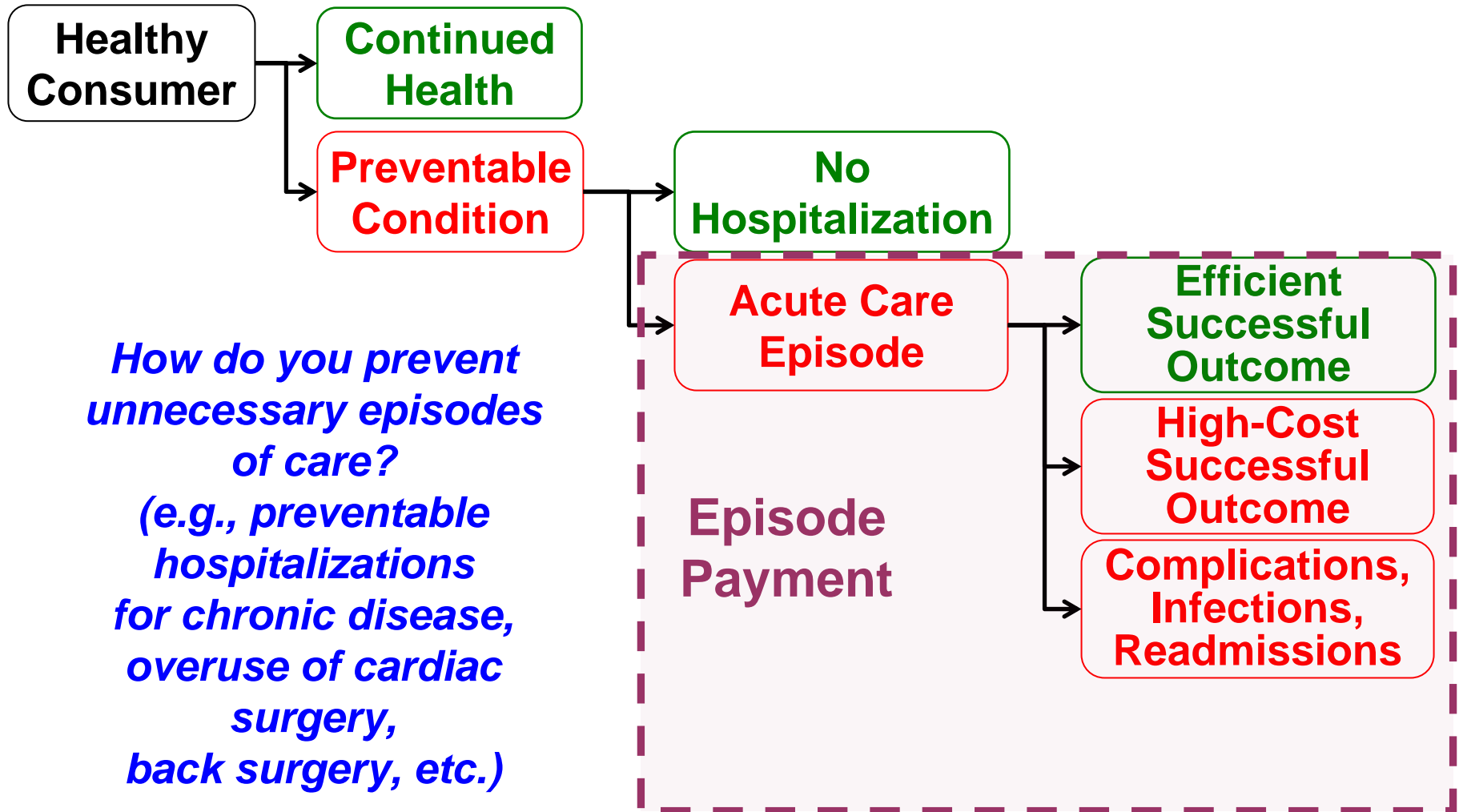
– A single payment for an ENTIRE 90 day period including:

- ALL related pre-admission care
- ALL inpatient physician and hospital services
- ALL related post-acute care
- ALL care for any related complications or readmissions

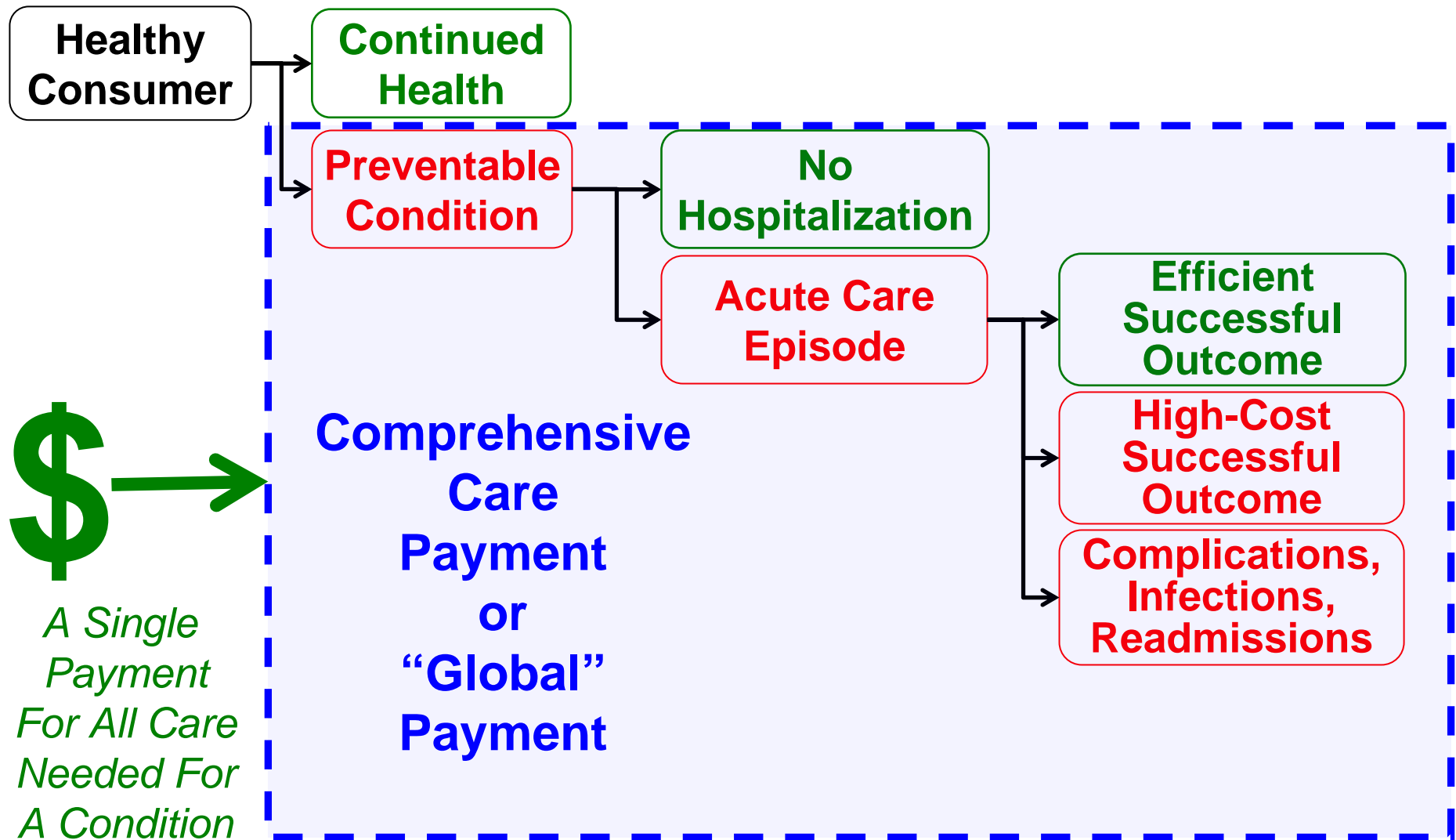
– Types of conditions/treatments currently offered:

- Cardiac Bypass Surgery
- Cardiac Stents
- Cataract Surgery
- Total Hip Replacement
- Bariatric Surgery
- Perinatal Care
- Low Back Pain
- Treatment of Chronic Kidney Disease

The Weakness of Episode Payment



Comprehensive Care Payments To *Avoid* Episodes



Isn't This Capitation?

No – It's Different

CAPITATION (WORST VERSIONS)

No Additional Revenue
for Taking Sicker
Patients

Providers Lose Money
On Unusually
Expensive Cases

Providers Are Paid
Regardless of the
Quality of Care

Provider Makes
More Money If
Patients Stay Well

Flexibility to Deliver
Highest-Value
Services

COMPREHENSIVE CARE PAYMENT

Payment Levels
Adjusted Based on
Patient Conditions

Limits on Total Risk
Providers Accept for
Unpredictable Events

Bonuses/Penalties
Based on Quality
Measurement

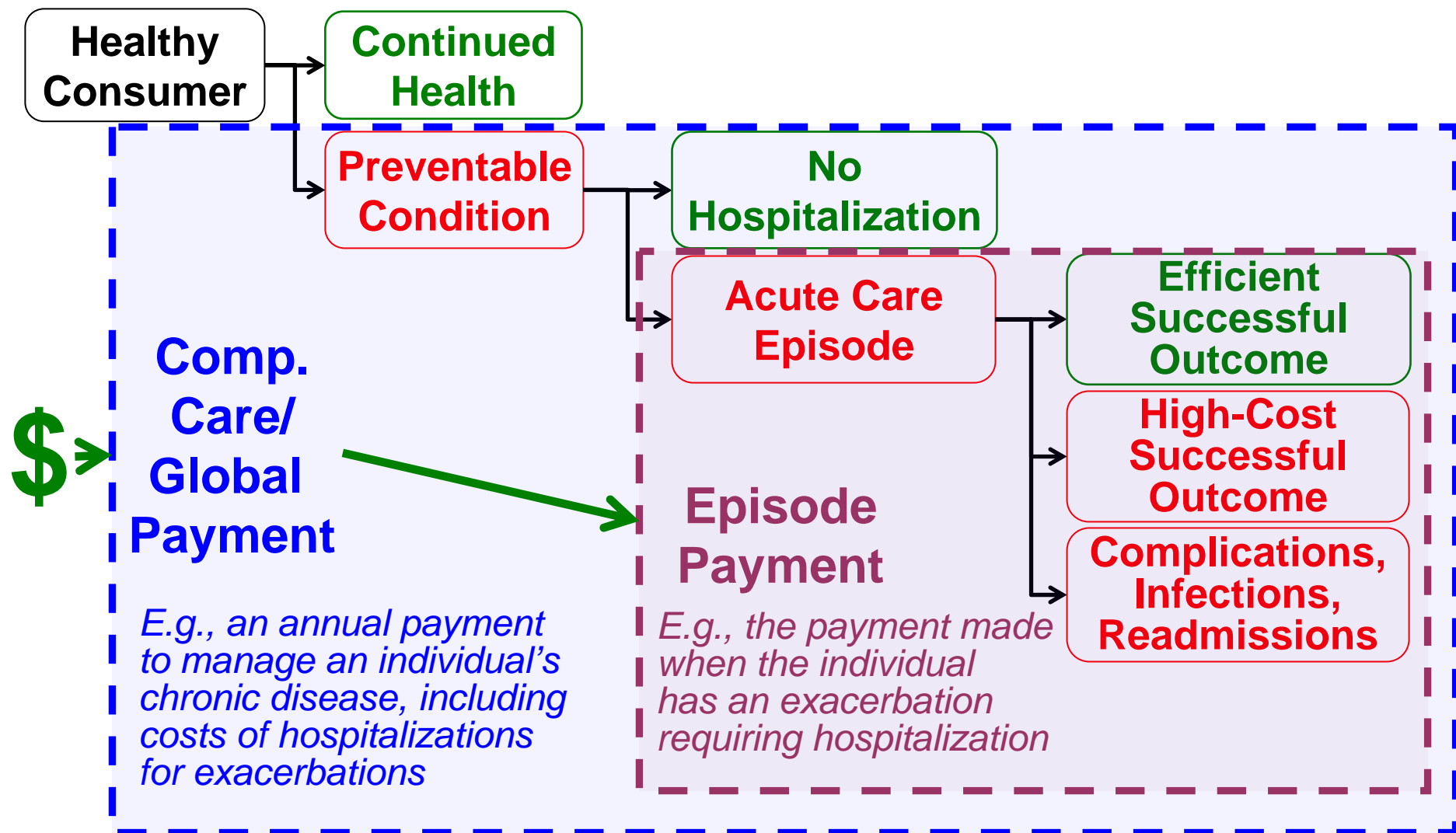
Provider Makes
More Money If
Patients Stay Well

Flexibility to Deliver
Highest-Value
Services

Example: BCBS Massachusetts Alternative Quality Contract

- A single payment amount is established to cover all costs of care for a population of patients
- The initial payment is set based on past expenditures; the amount increases each year at an inflation rate based on CPI, not on medical inflation, so savings come from controlling increases over time
- The payment amount functions as a budget; the budget is adjusted up or down based on the types and severity of conditions the patients have, so providers aren't taking insurance risk, only performance risk
- The provider doesn't need to pay claims; BCBS still pays individual providers fee-for-service, but fees are adjusted up or down to keep total costs within the payment budget
- Payments are increased by annual bonuses based on the quality of care delivered

Comprehensive Care & Episode Payment Can Be Complementary



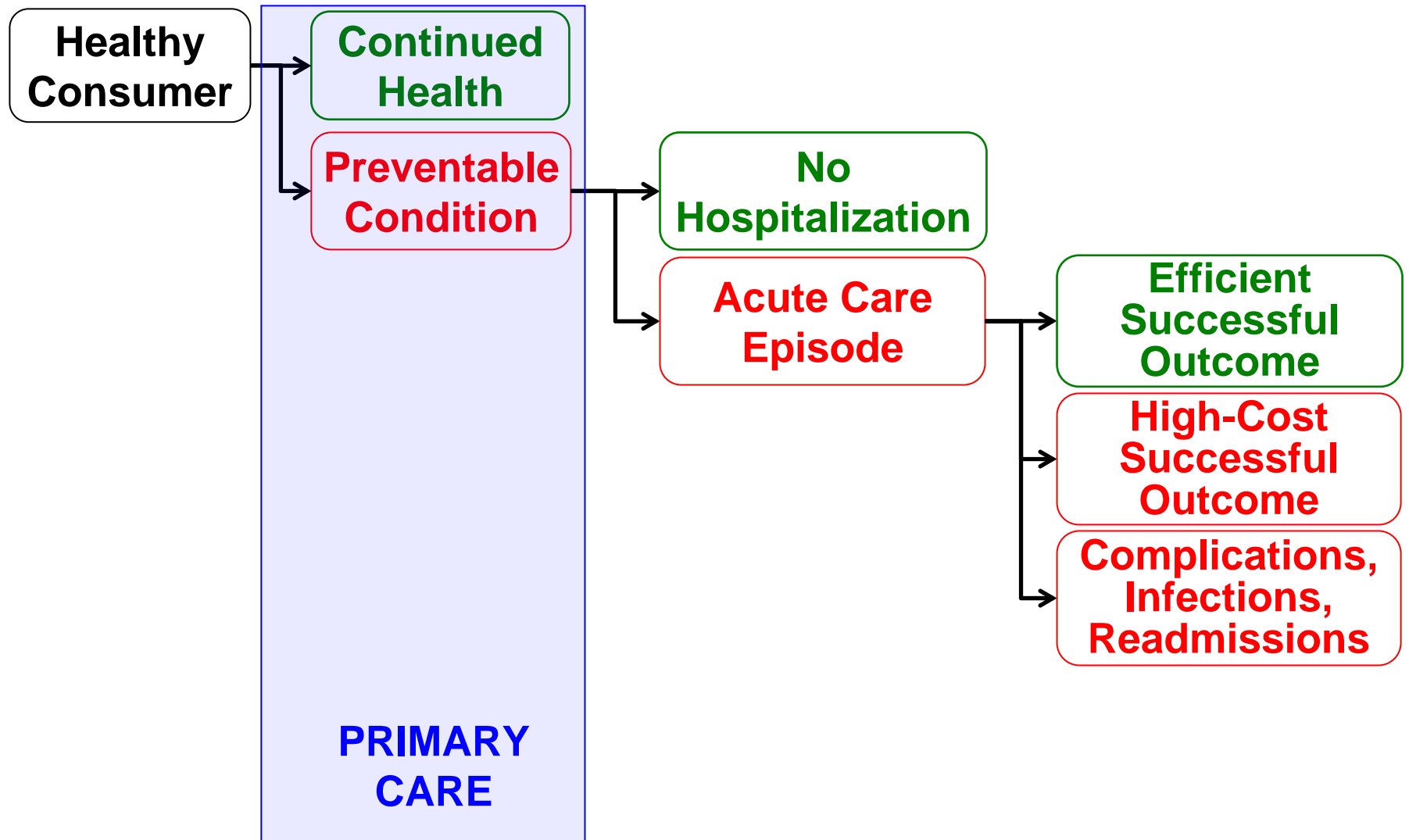
Examples of Comprehensive Care + Episode Payment

Condition	Comprehensive Care Payment	Episode Payment
Pregnancy	Maternity Care (Prenatal Care + Childbirth + Postnatal Care)	Childbirth
Heart Disease	Heart Care (Weight/Cholesterol Reduction, Smoking Cessation, Medical Management, Surgery)	Bypass Surgery
		Stenting
COPD	Chronic Disease Management	Hospitalization for COPD Exacerbation
		Hospitalization for Pneumonia

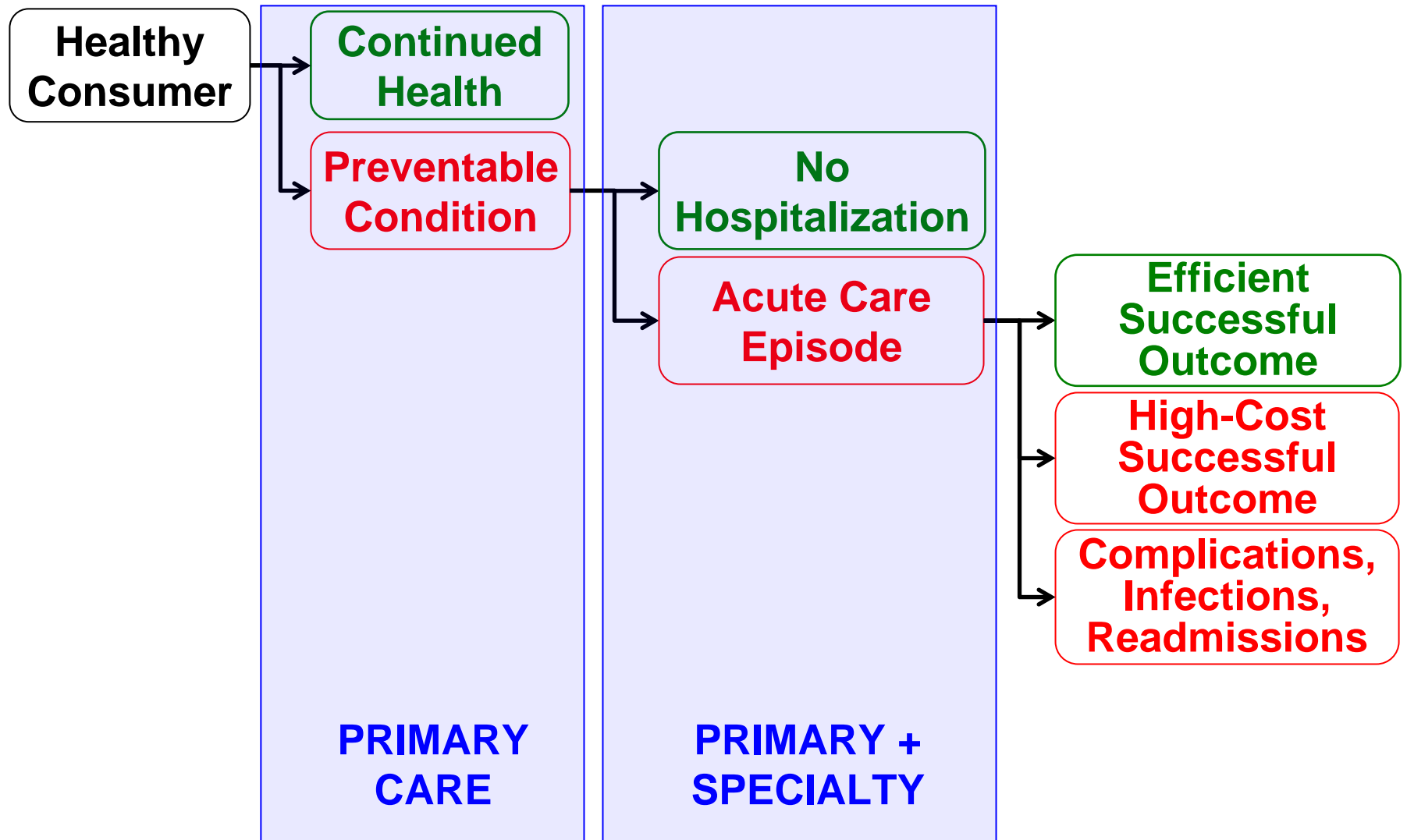
Who Should Be Accountable For Achieving Higher Value Care?

- Hospitals?
- Integrated Delivery Systems?
- Multi-Specialty Group Practices?

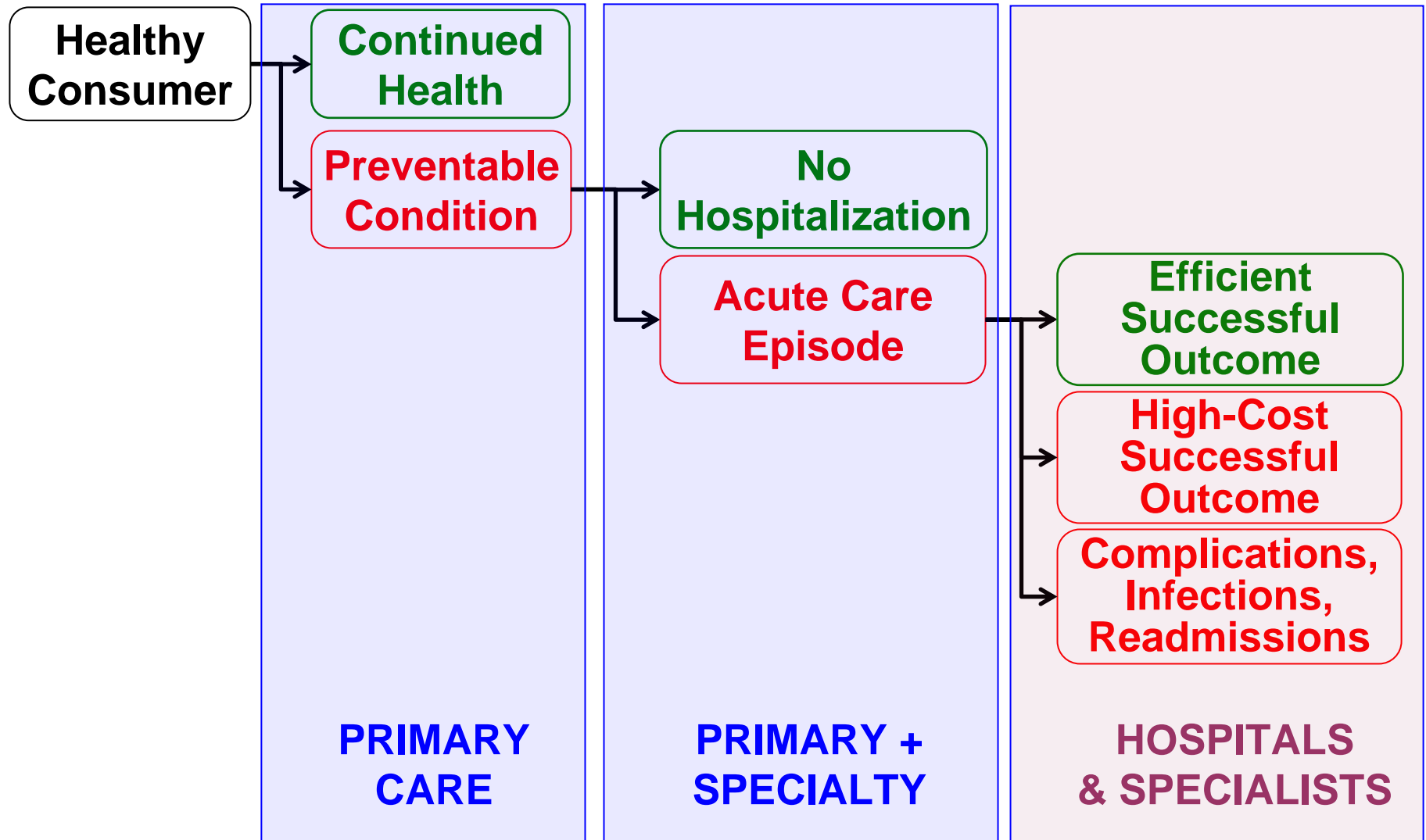
Keeping People Well? Primary Care



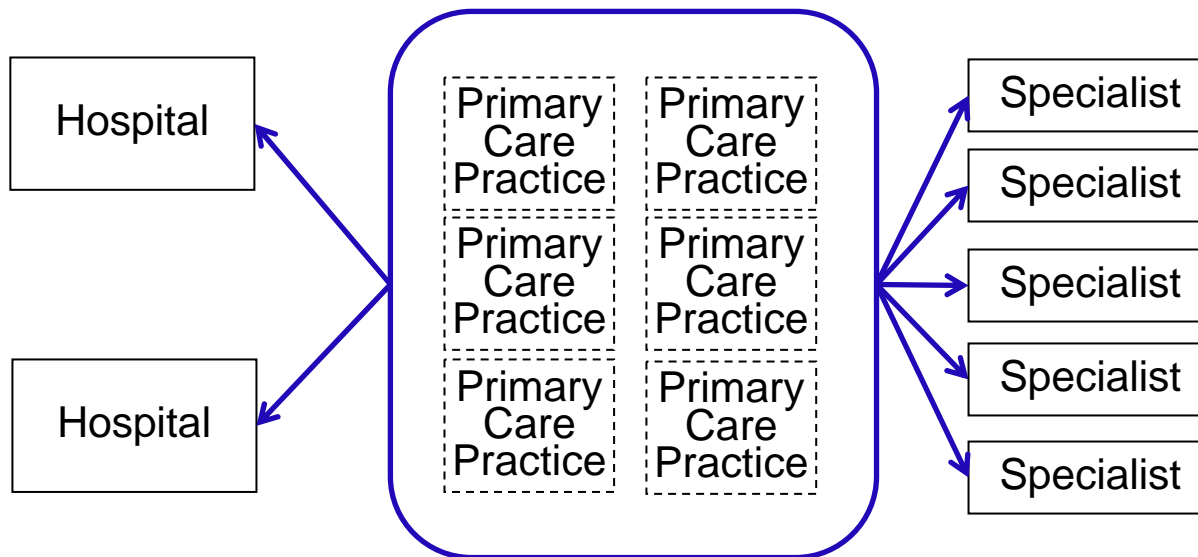
Avoiding Hospitalizations? Primary + Specialty Care



Better Acute Care? Hospitals and Specialists



Primary Care Must Be the Core of an ACO



Don't Let the Perfect Be the Enemy of the Good

AREAS NEEDING COST CONTROL & IMPROVEMENT

*If you try to tackle ALL
cost issues at once
(after not tackling any
of them for decades)...*

Better Management
of Complex and
Low-Income Patients

Greater Efficiency &
Improved Outcomes
for Inpatient Care

Improved Outcomes
and Efficiency for
Major Specialties

Reduction in
Preventable ER
Visits & Admissions

Appropriate Use of
Testing/Referral

Prevention &
Early Diagnosis

Only Large Systems Could Even Try to Tackle All Costs At Once

HEALTH CARE PROVIDERS REQUIRED

AREAS NEEDING COST CONTROL & IMPROVEMENT

...you'll have to have every provider change all at once for all patients

Public Health	
Safety-Net Clinics	
Hospitals	
Other Specialists	
Major Specialists (Cardiology, Orthopedics, Etc.)	
Primary Care Practice	Primary Care Practice
Primary Care Practice	Primary Care Practice
Primary Care Practice	Primary Care Practice

Better Management of Complex and Low-Income Patients
Greater Efficiency & Improved Outcomes for Inpatient Care
Improved Outcomes and Efficiency for Major Specialties
Reduction in Preventable ER Visits & Admissions
Appropriate Use of Testing/Referral
Prevention & Early Diagnosis

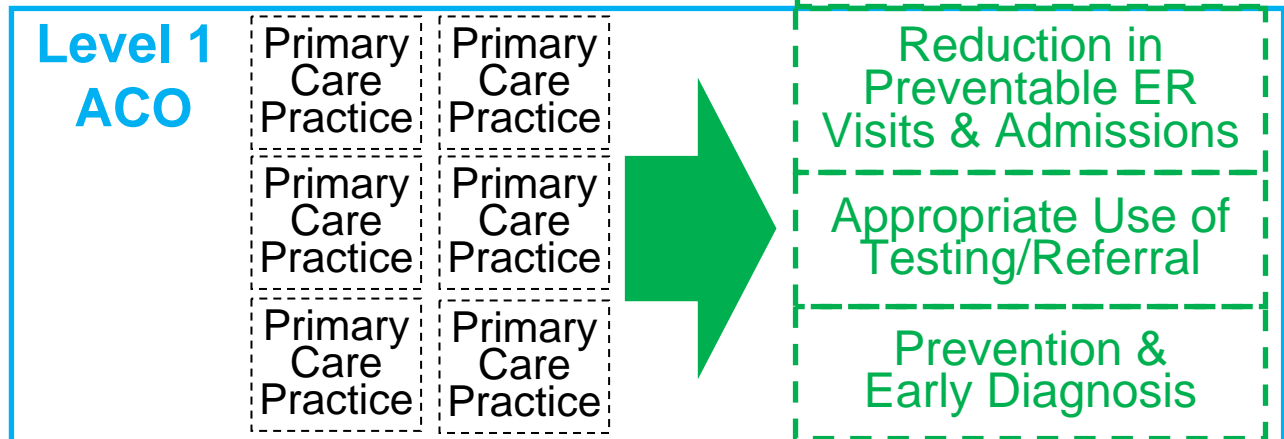
Weaknesses of “Shared Savings”

- Requires TOTAL costs to go down in order for the ACO to receive ANY increase in payment, even if the ACO can't control all costs
- Provides no upfront money to enable primary care practices to hire nurse care managers, install IT, etc.; additional funds, if any, come years after the care changes are made
- Gives more rewards to the *poor* performers who improve than the providers who've done well all along
- It's not sustainable – once costs are reduced, there is less to be “saved” and so shared savings payments disappear, while costs of care management remain
- I.e., it's not really *payment reform*

“Level 1” ACO: What PCPs Alone Can Tackle

**HEALTH CARE
PROVIDERS
REQUIRED**

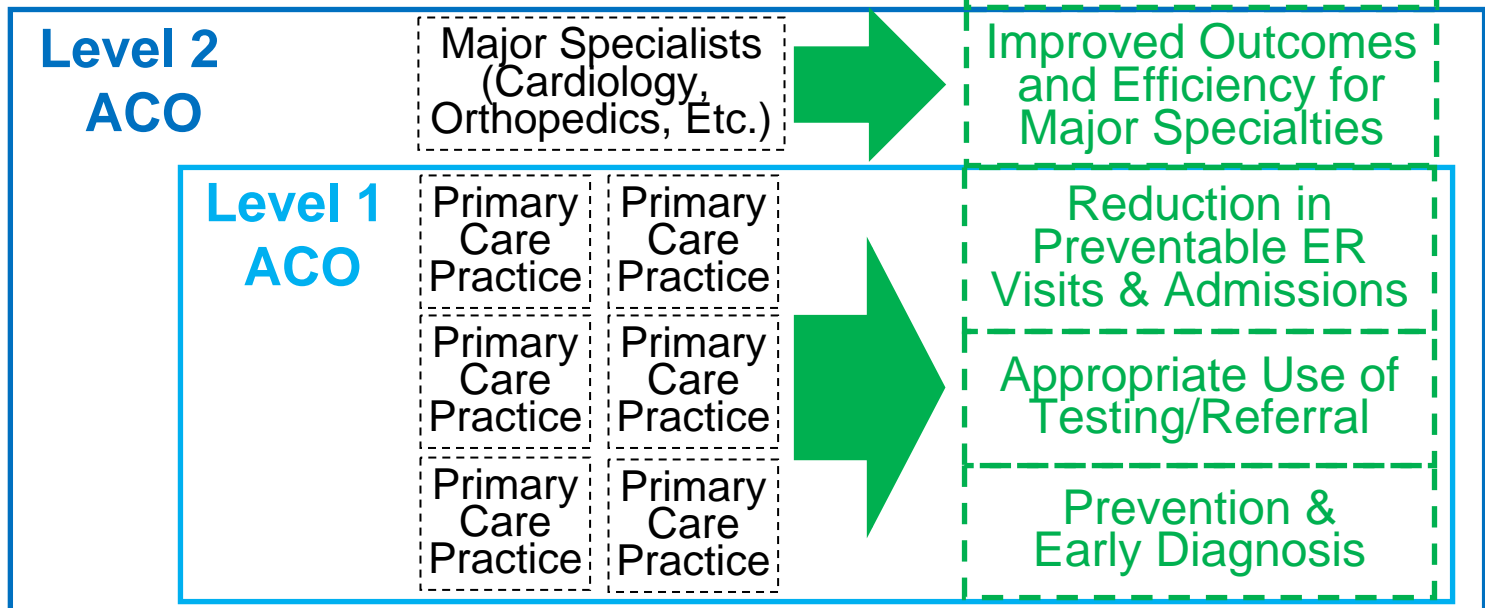
**AREAS NEEDING
COST CONTROL
& IMPROVEMENT**



“Level 2” ACO: PCPs + Key Specialists

HEALTH CARE PROVIDERS REQUIRED

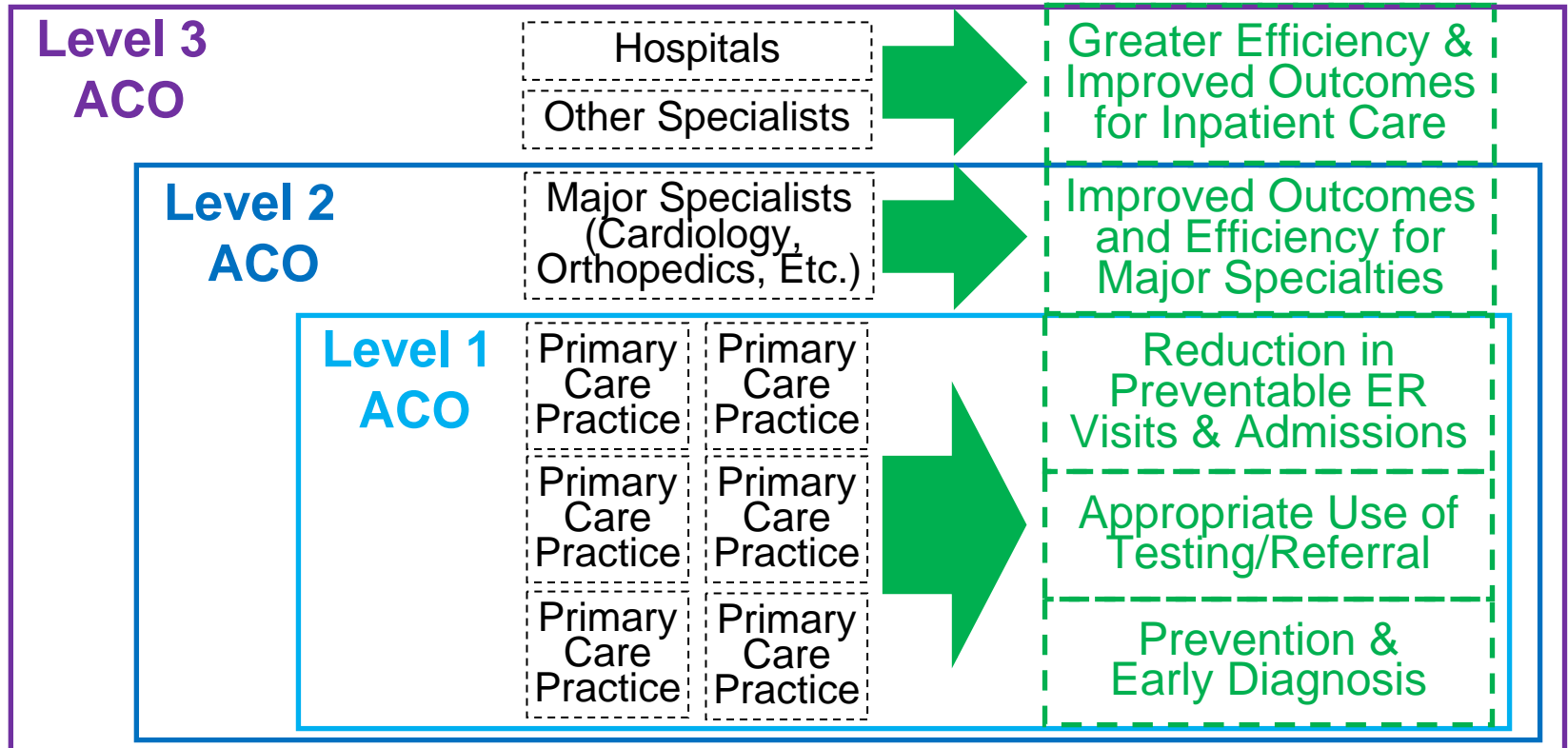
AREAS NEEDING COST CONTROL & IMPROVEMENT



“Level 3” ACO: PCPs + Specialists + Hospital(s)

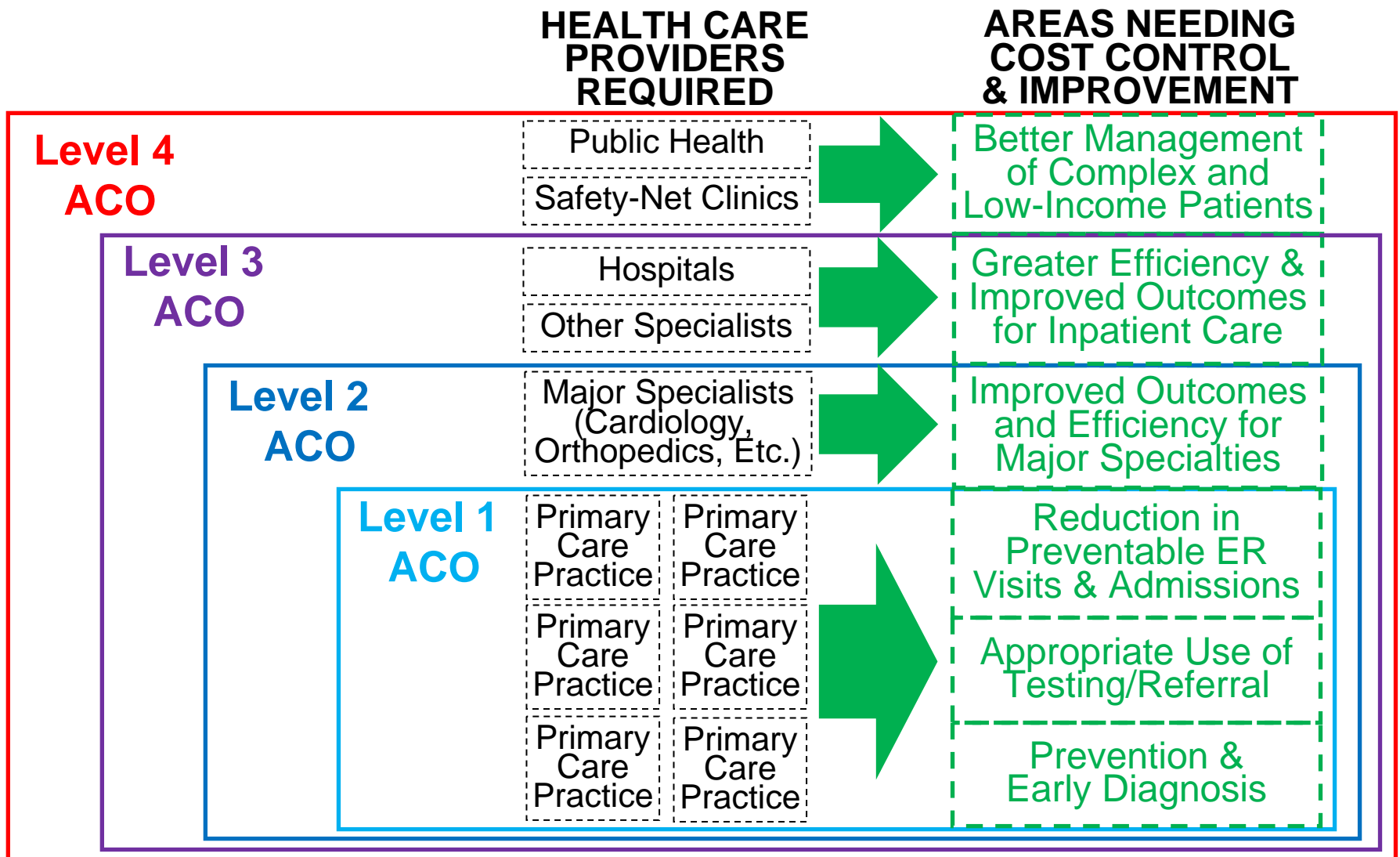
HEALTH CARE PROVIDERS REQUIRED

AREAS NEEDING COST CONTROL & IMPROVEMENT



“Level 4” ACO:

Integrated Medical & Social Svcs



Organizational Structures to Support Accountable Care

HEALTH CARE PROVIDERS REQUIRED

EXAMPLES OF ORGANIZATIONAL STRUCTURES

Level 4 ACO

Public Health
Safety-Net Clinics

Level 3 ACO

Hospitals
Other Specialists

Level 2 ACO

Major Specialists
(Cardiology,
Orthopedics, Etc.)

Level 1 ACO

Primary Care Practice	Primary Care Practice
Primary Care Practice	Primary Care Practice
Primary Care Practice	Primary Care Practice

*Primary Care
Group Practice;
Independent Practice
Association*

Organizational Structures to Support Accountable Care

HEALTH CARE PROVIDERS REQUIRED

EXAMPLES OF ORGANIZATIONAL STRUCTURES

Level 4 ACO

Public Health
Safety-Net Clinics

Level 3 ACO

Hospitals
Other Specialists

Level 2 ACO

Major Specialists
(Cardiology,
Orthopedics, Etc.)

*Multi-Specialty
Group Practice or IPA*

Level 1 ACO

Primary Care Practice	Primary Care Practice
Primary Care Practice	Primary Care Practice
Primary Care Practice	Primary Care Practice

*Primary Care
Group Practice;
Independent Practice
Association*

Organizational Structures to Support Accountable Care

HEALTH CARE PROVIDERS REQUIRED

EXAMPLES OF ORGANIZATIONAL STRUCTURES

**Level 4
ACO**

Public Health
Safety-Net Clinics

**Level 3
ACO**

Hospitals
Other Specialists

*Integrated Delivery System;
Physician-Hospital Org.*

**Level 2
ACO**

Major Specialists
(Cardiology,
Orthopedics, Etc.)

*Multi-Specialty
Group Practice or IPA*

**Level 1
ACO**

Primary Care Practice	Primary Care Practice
Primary Care Practice	Primary Care Practice
Primary Care Practice	Primary Care Practice

*Primary Care
Group Practice;
Independent Practice
Association*

Organizational Structures to Support Accountable Care

HEALTH CARE PROVIDERS REQUIRED

EXAMPLES OF ORGANIZATIONAL STRUCTURES

**Level 4
ACO**

Public Health
Safety-Net Clinics

**Systems Like
Denver Health**

**Level 3
ACO**

Hospitals
Other Specialists

**Integrated Delivery System;
Physician-Hospital Org.**

**Level 2
ACO**

Major Specialists
(Cardiology,
Orthopedics, Etc.)

**Multi-Specialty
Group Practice or IPA**

**Level 1
ACO**

Primary Care Practice	Primary Care Practice
Primary Care Practice	Primary Care Practice
Primary Care Practice	Primary Care Practice

**Primary Care
Group Practice;
Independent Practice
Association**

Key is *Clinical* Integration, Not Corporate Integration

**HEALTH CARE
PROVIDERS
REQUIRED**

**EXAMPLES OF
ORGANIZATIONAL
STRUCTURES**

**Level 3
ACO**

Hospitals	
Other Specialists	
Major Specialists (Cardiology, Orthopedics, Etc.)	
Primary Care Practice	Primary Care Practice
Primary Care Practice	Primary Care Practice
Primary Care Practice	Primary Care Practice

Integrated Delivery System

=

Corporate Health System

OR

***Independent Practice
Association***

+

Contracts w/ Specialists

+

Contracts w/ Hospitals

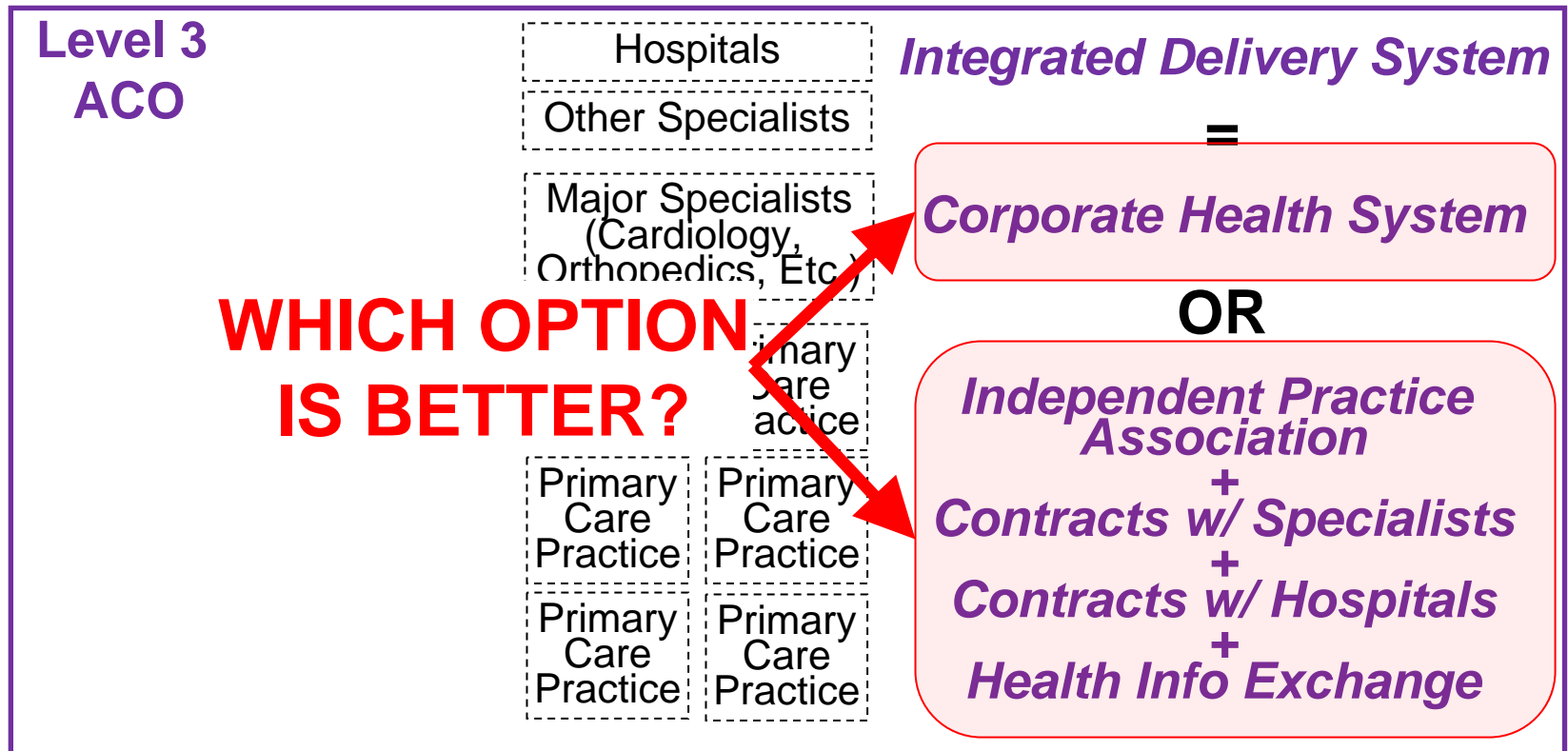
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Health Info Exchange

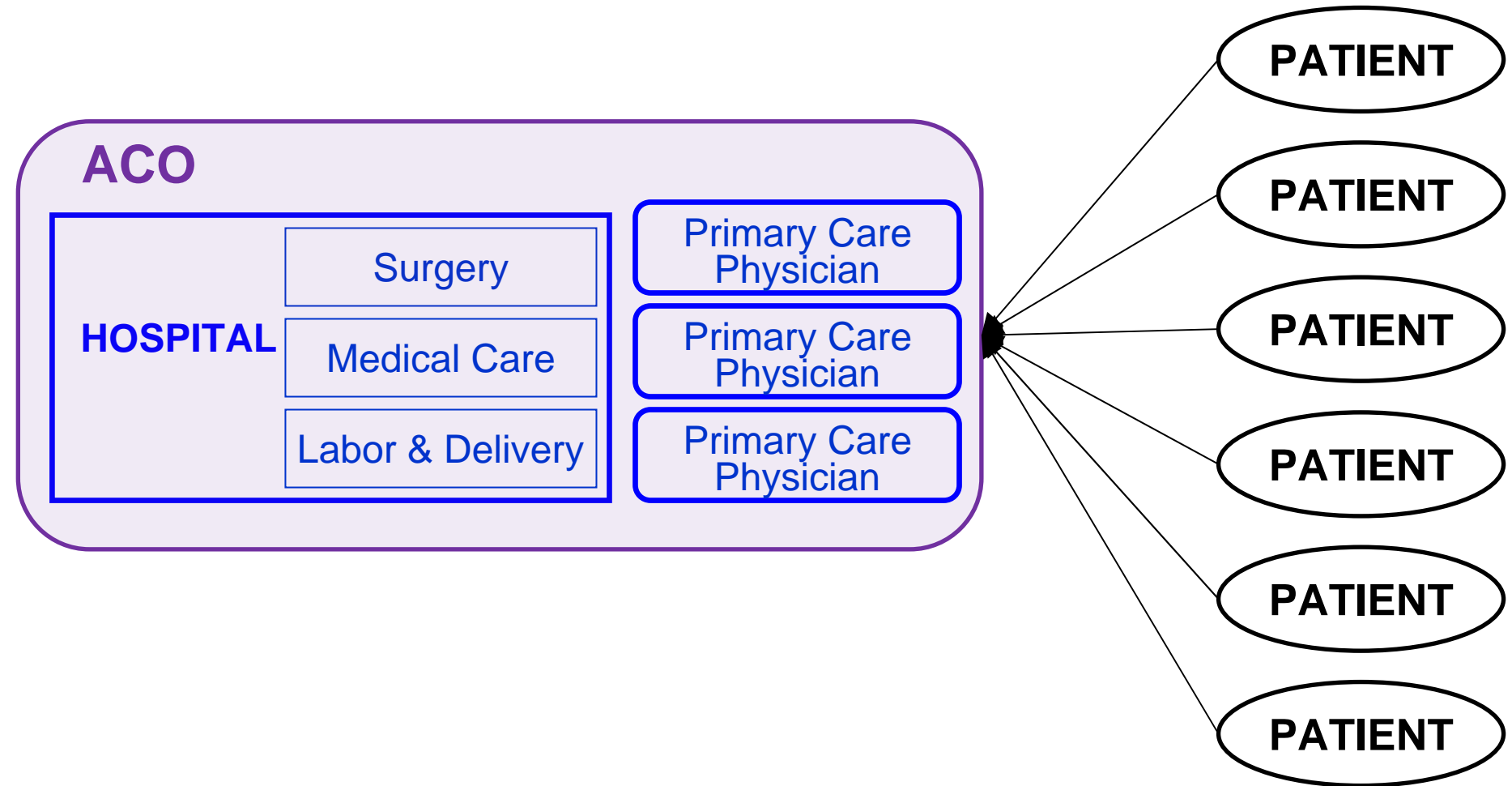
Isn't an Integrated Health System the Ideal?

HEALTH CARE PROVIDERS INCLUDED

EXAMPLES OF ORGANIZATIONAL STRUCTURES



From Health System Perspective: ACO = Our Hospital + PCPs



Looking Through the Patient's (& Purchaser's) Eyes

PATIENT

REGION

High Quality
Primary Care
Physician

Avg. Quality
Primary Care
Physician

Low Quality
Primary Care
Physician

High Cost/Low Quality
Orthopedic Surgery

Low Cost/High Quality
Cardiac Surgery

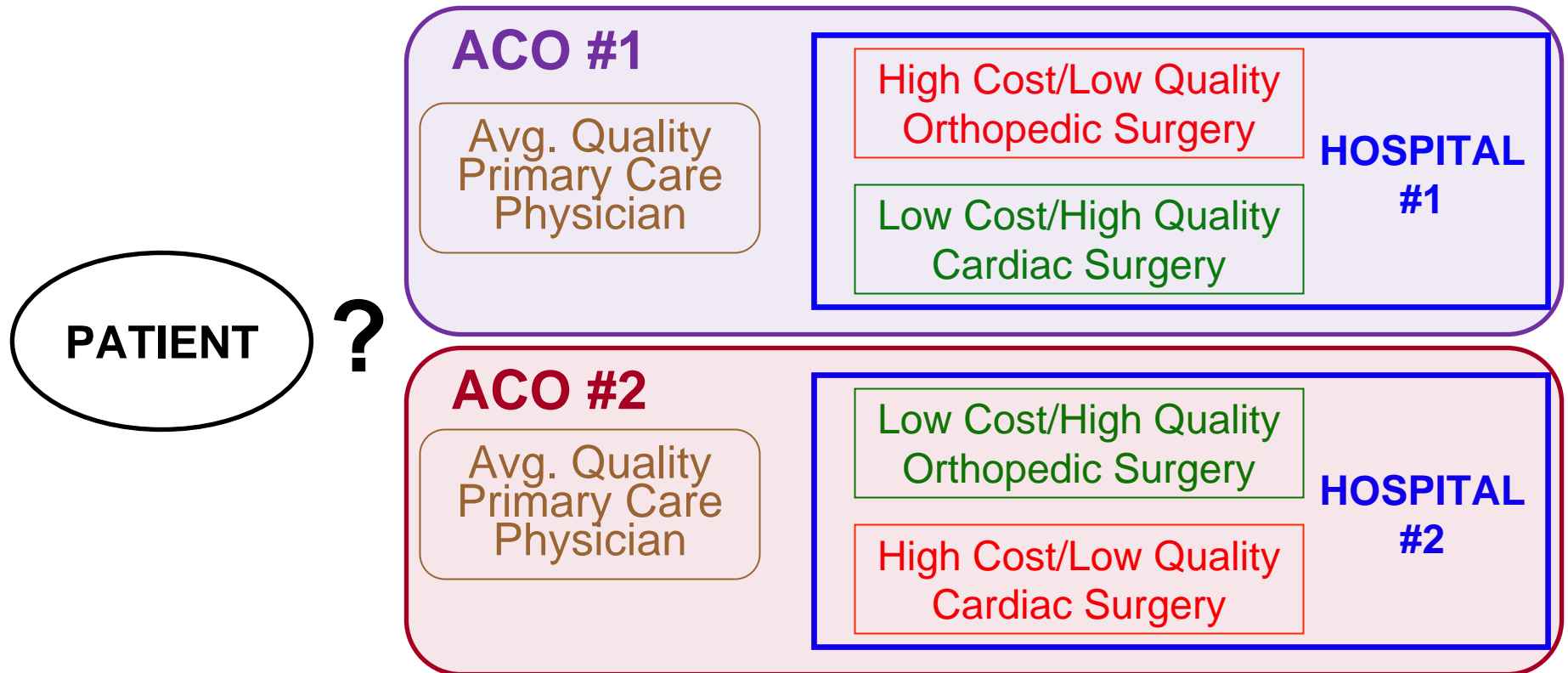
**HOSPITAL
#1**

Low Cost/High Quality
Orthopedic Surgery

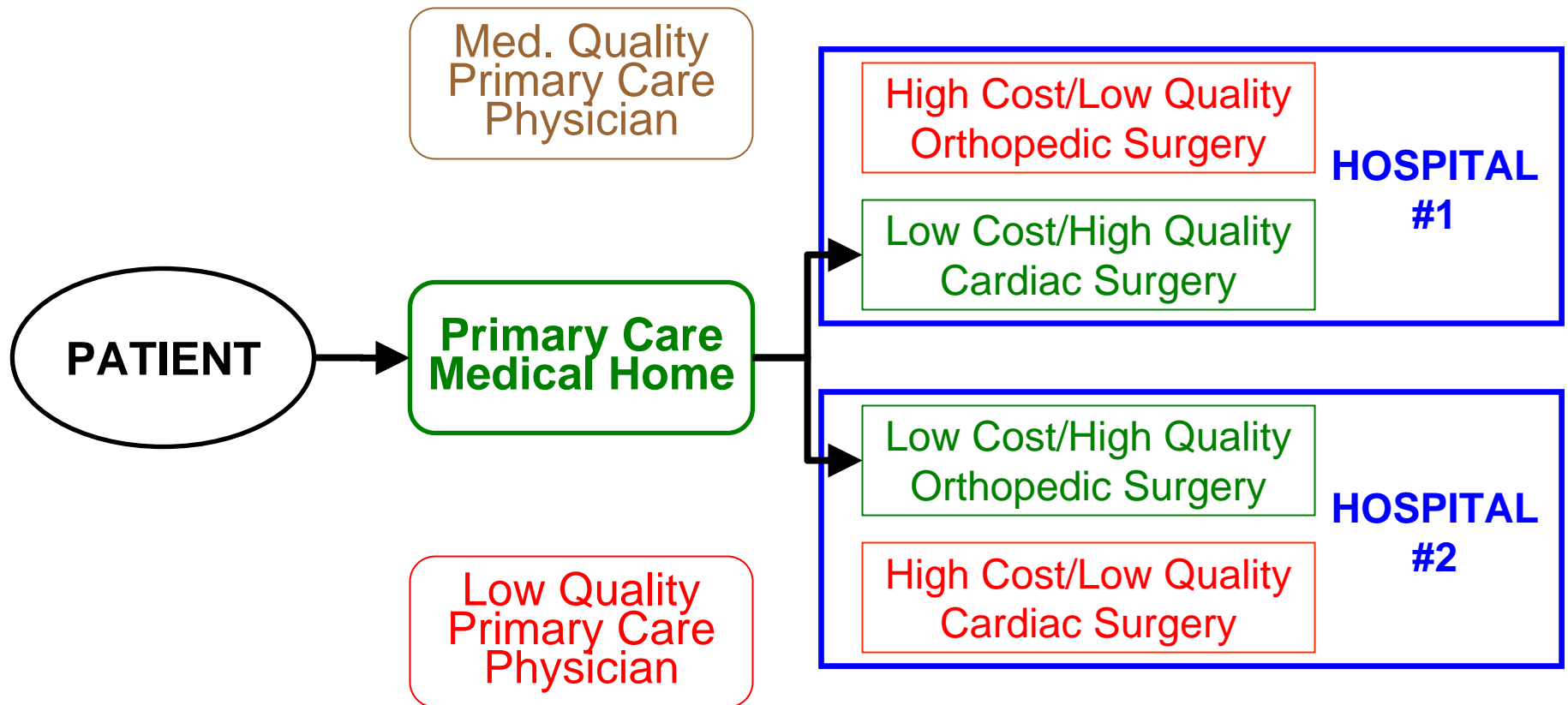
High Cost/Low Quality
Cardiac Surgery

**HOSPITAL
#2**

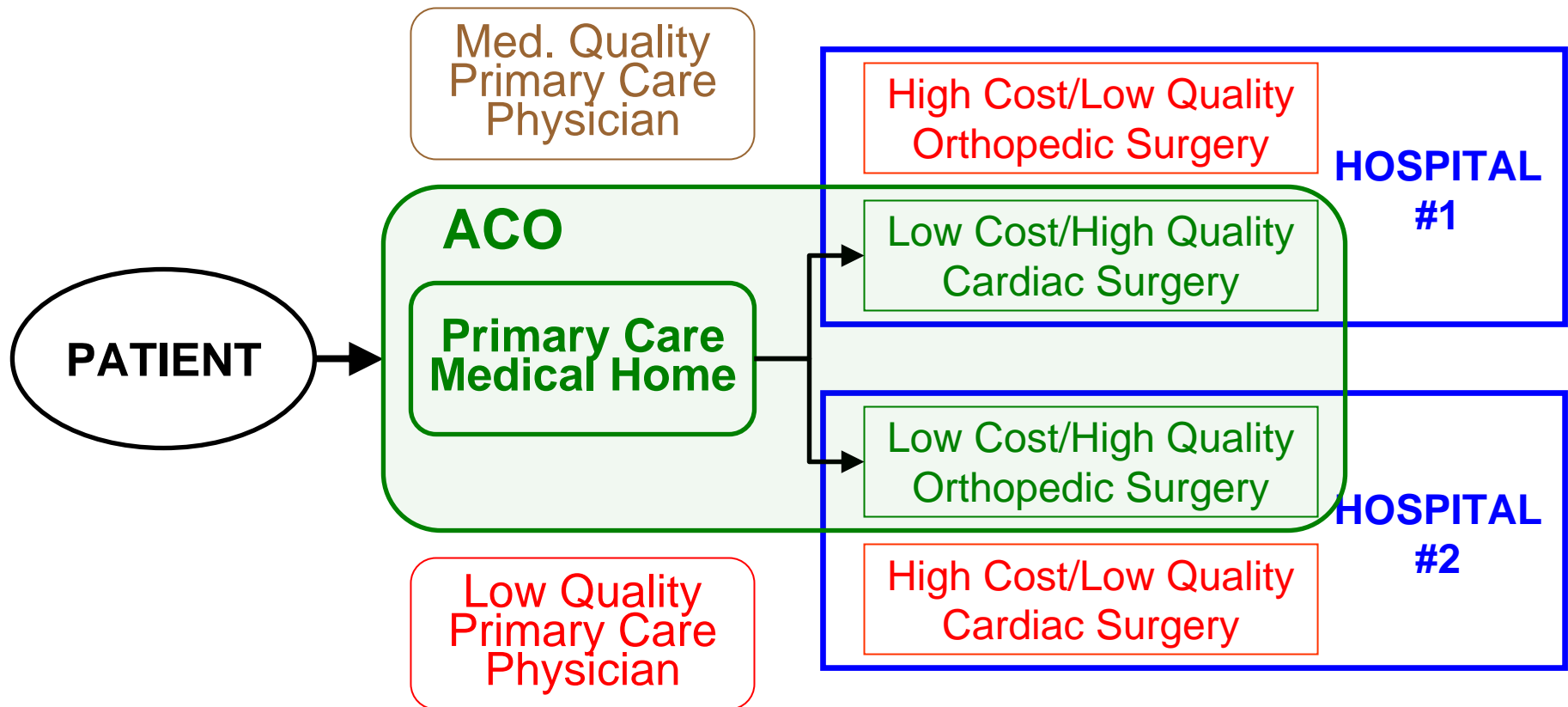
Who Will Want to Choose Hospital-Centric Networks??



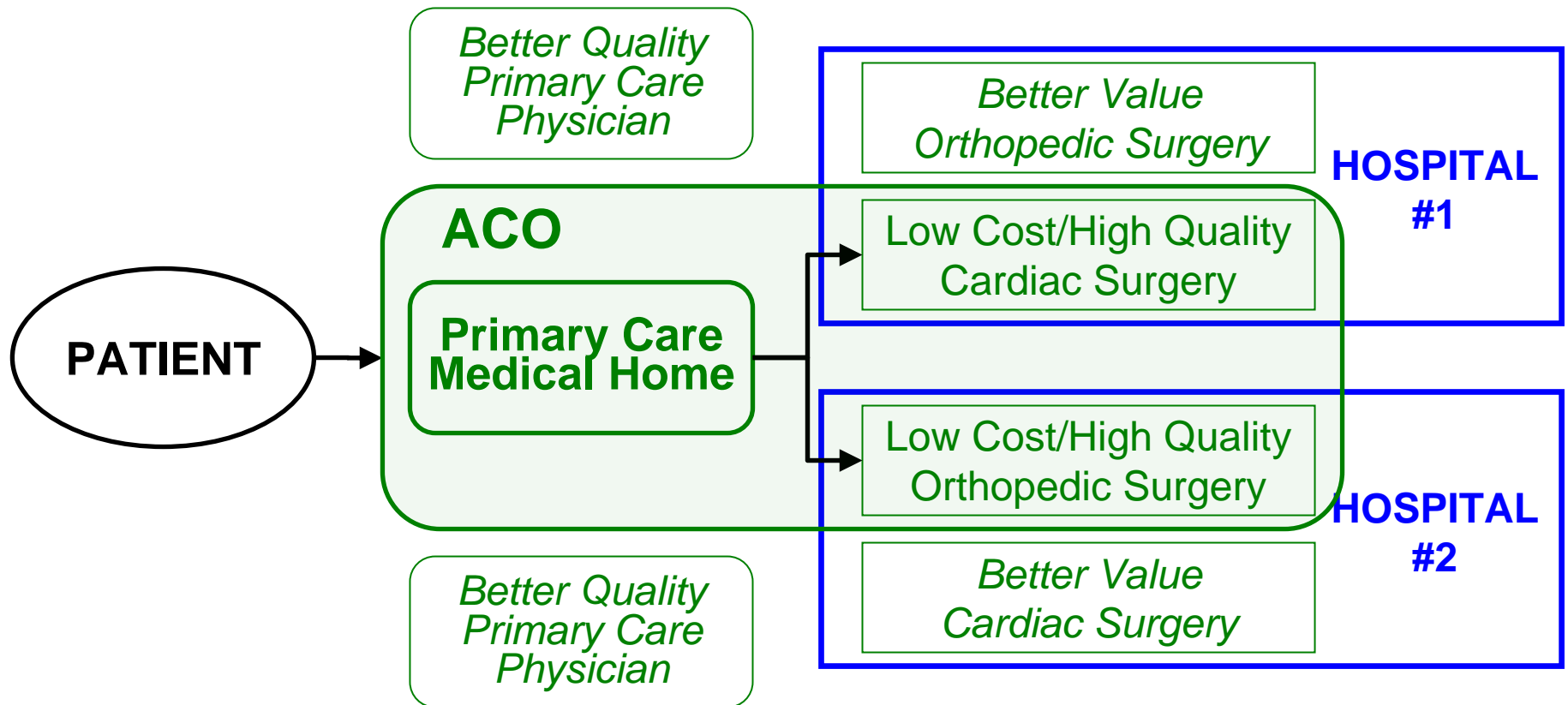
Patients Will Want: Medical Homes nrhi+ Value-Based Acute Care Choice



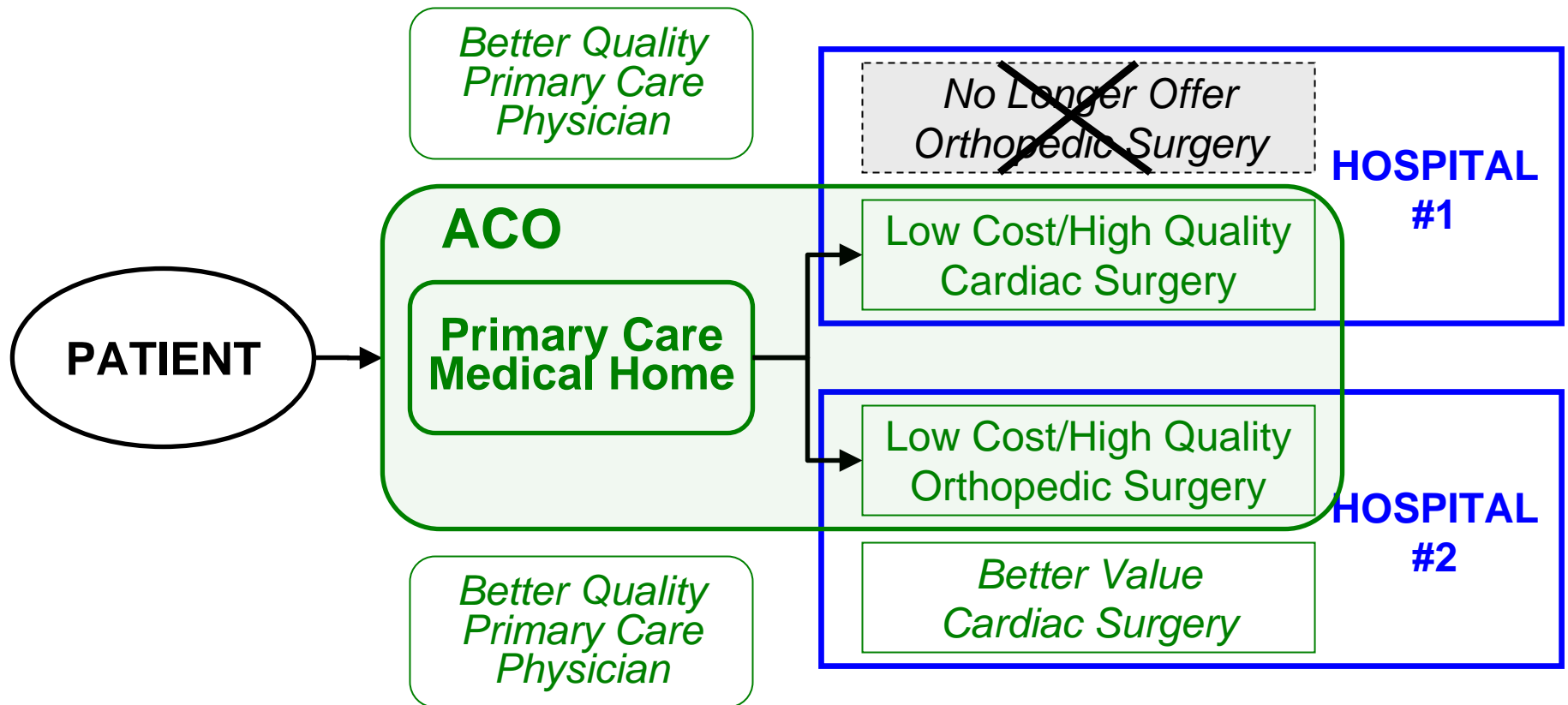
The Right Way to Define ACOs...



...And the Right Way to Stimulate Improvement In Other Services...

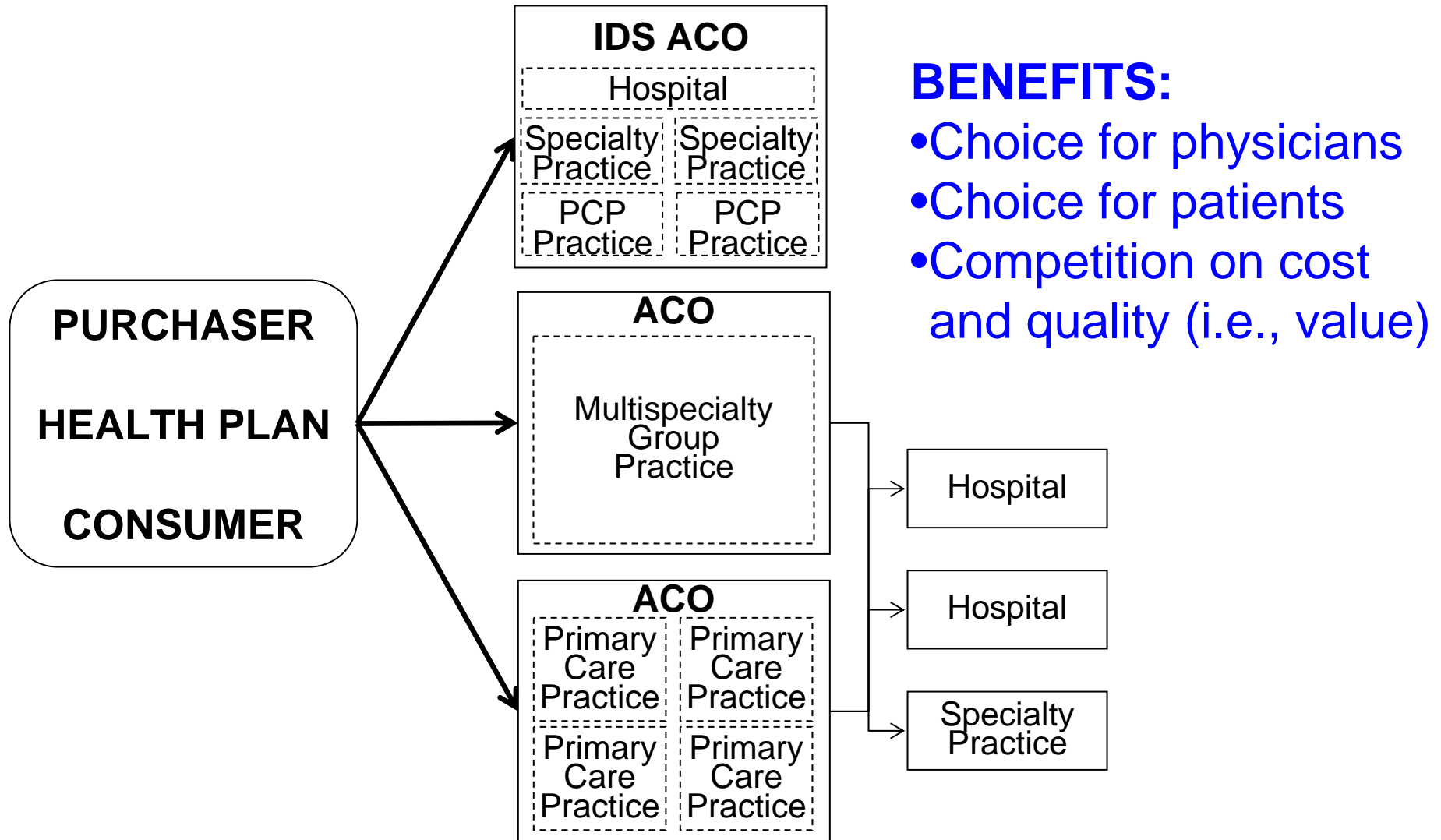


...Or See Low Quality Services Disappear



How Many ACOs in a Region?

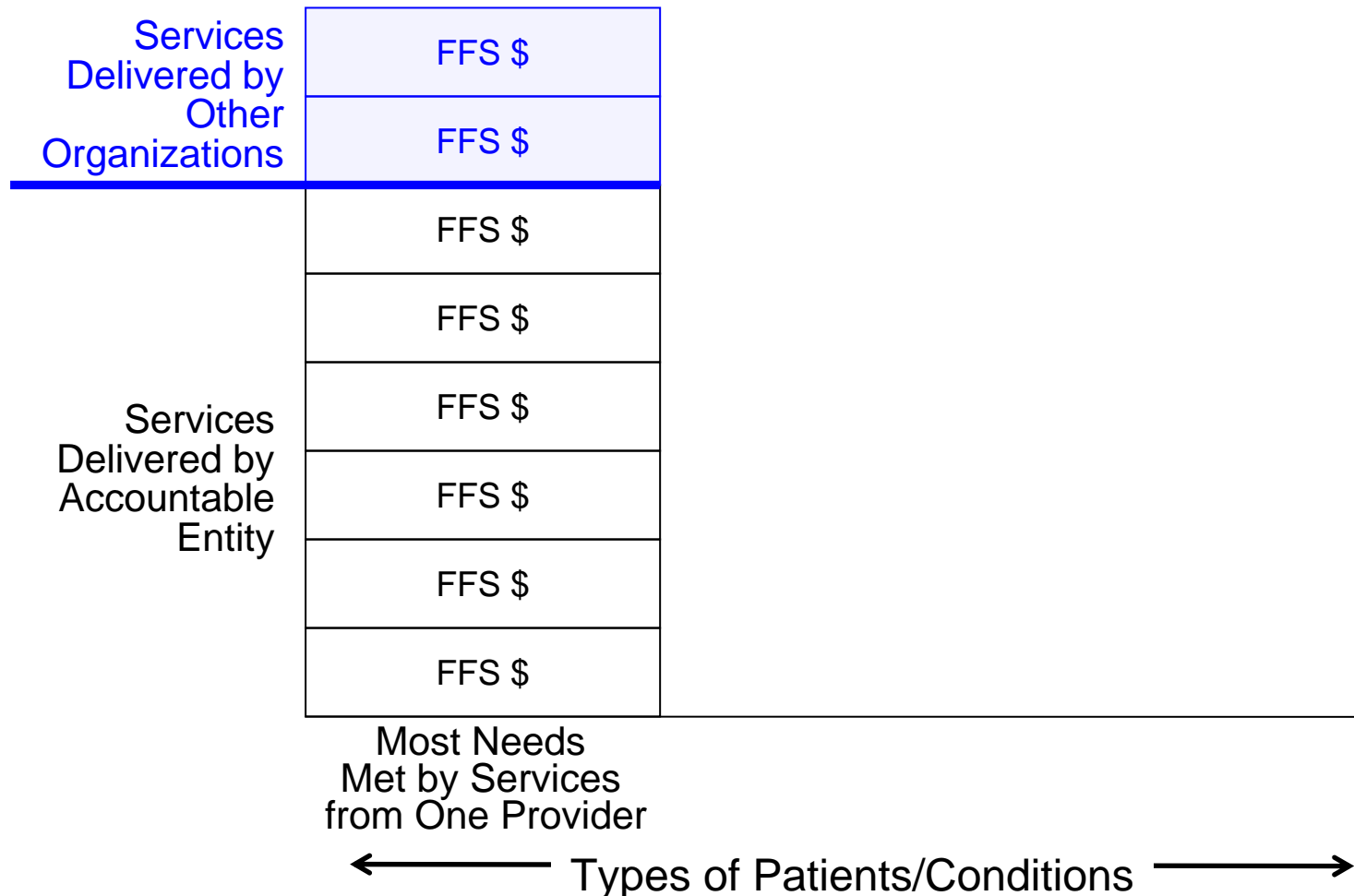
Multiple, “Right-Sized” ACOs



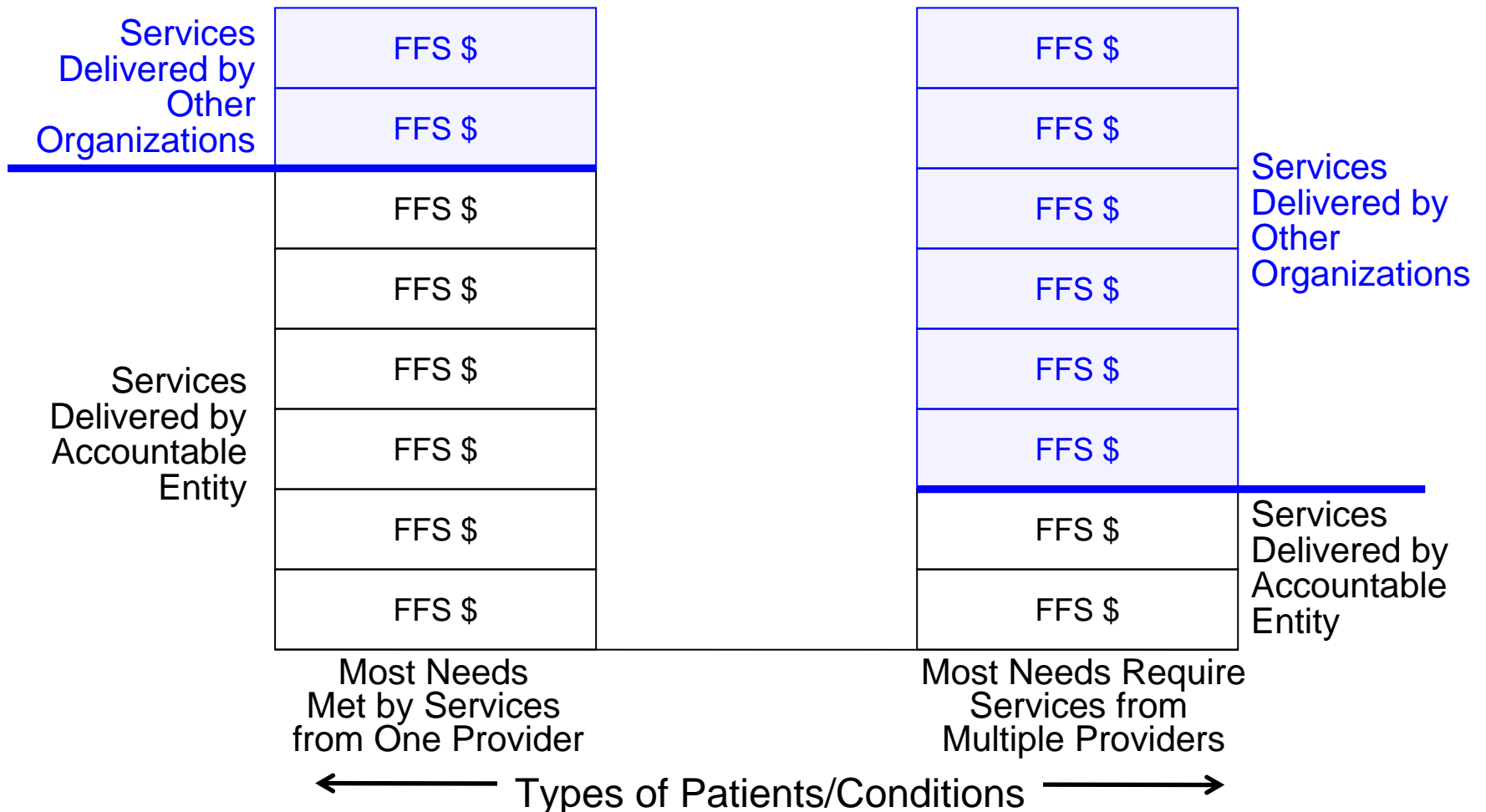
BENEFITS:

- Choice for physicians
- Choice for patients
- Competition on cost and quality (i.e., value)

An ACO Will Deliver Most/All Services to *Some* Patients...



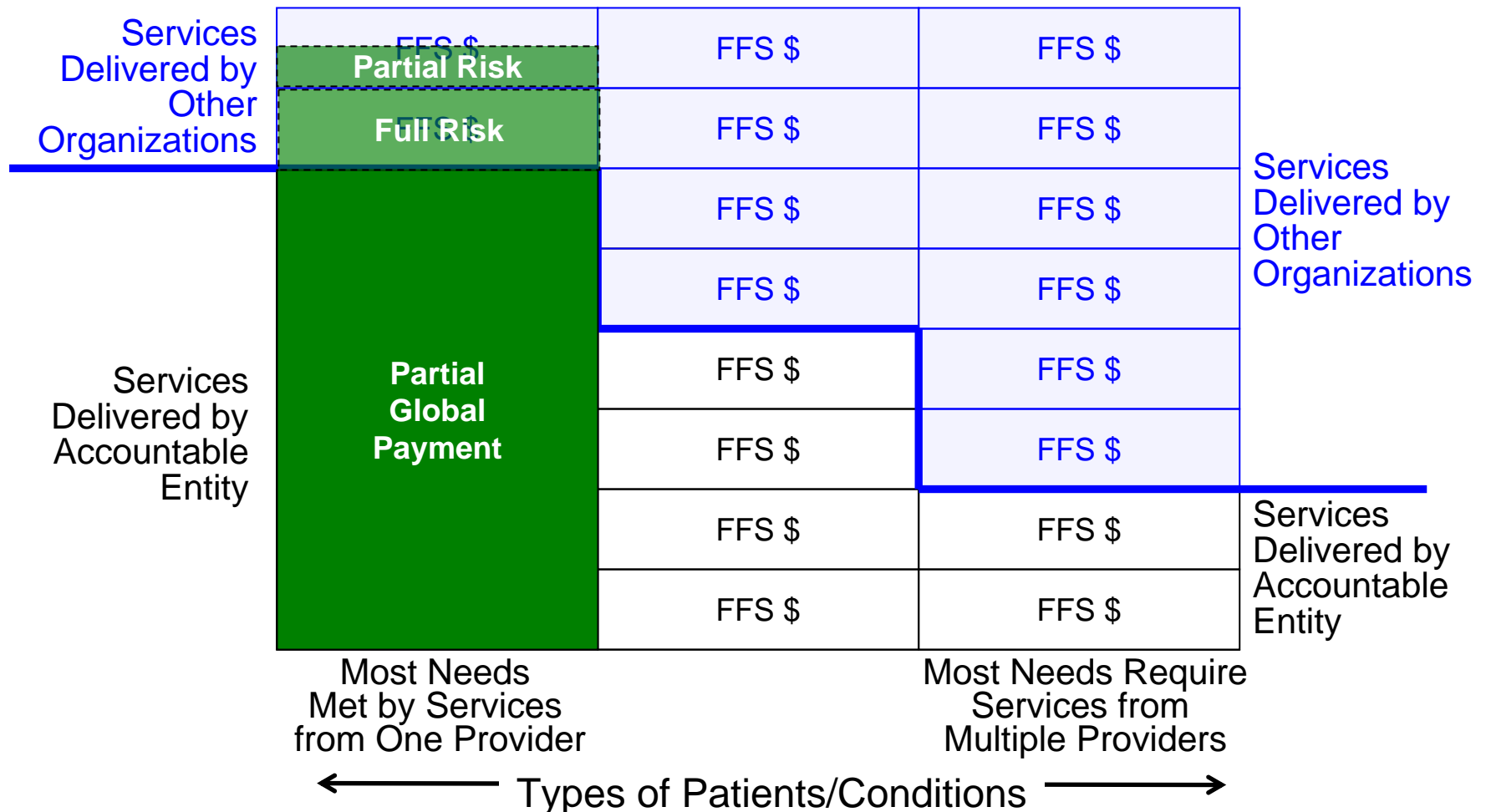
...Other Patients Will Need More Services From Other Providers



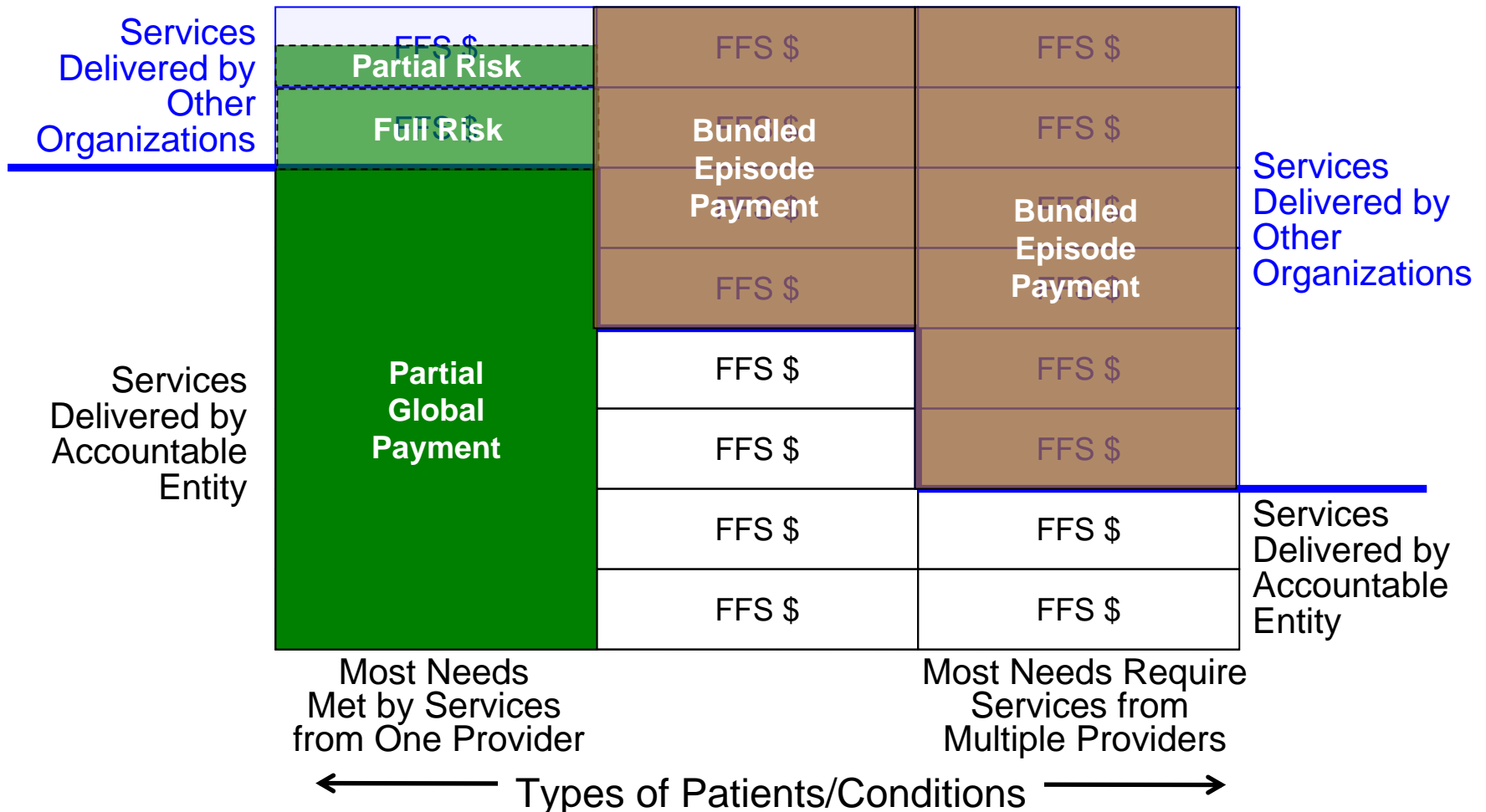
How Should Payment Support This?

Services Delivered by Other Organizations	FFS \$	FFS \$	FFS \$	Services Delivered by Other Organizations
	FFS \$	FFS \$	FFS \$	
Services Delivered by Accountable Entity	FFS \$	FFS \$	FFS \$	Services Delivered by Accountable Entity
	FFS \$	FFS \$	FFS \$	
	FFS \$	FFS \$	FFS \$	
	FFS \$	FFS \$	FFS \$	
	FFS \$	FFS \$	FFS \$	
	FFS \$	FFS \$	FFS \$	
	Most Needs Met by Services from One Provider		Most Needs Require Services from Multiple Providers	
← Types of Patients/Conditions →				

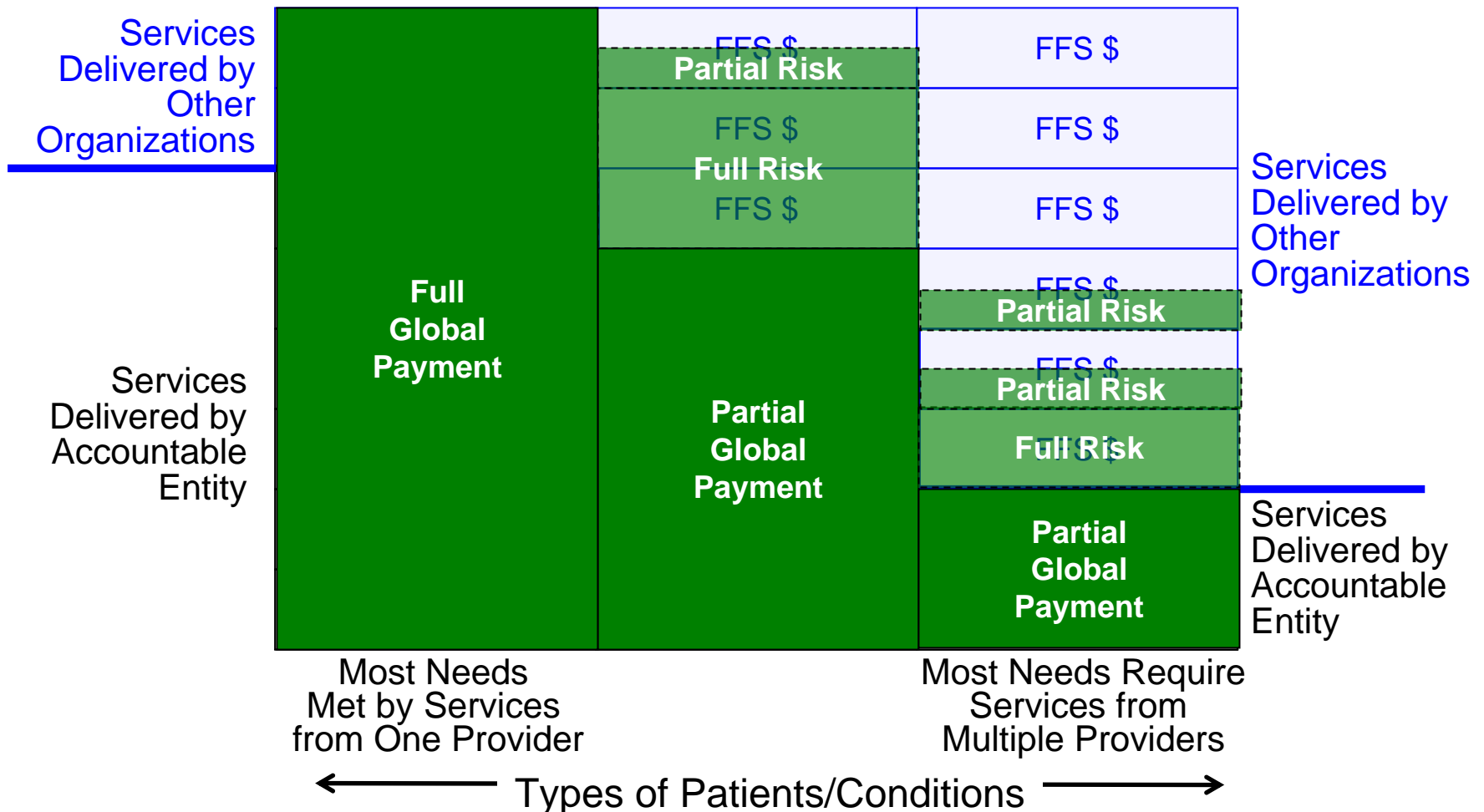
Start with a Subset of Patients and Partial Risk for Costs



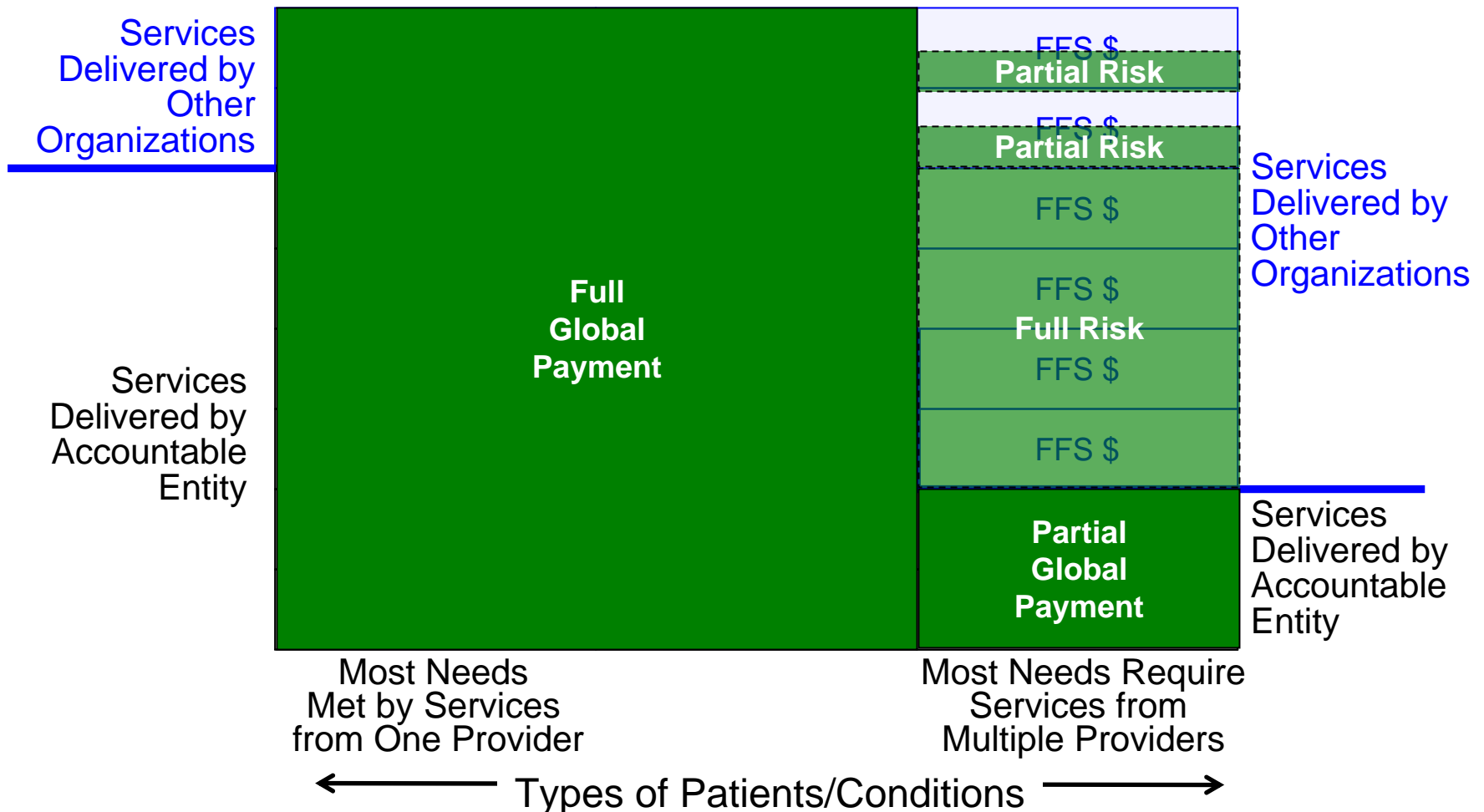
Use Episode Payments to Help Control Out-of-Network Costs



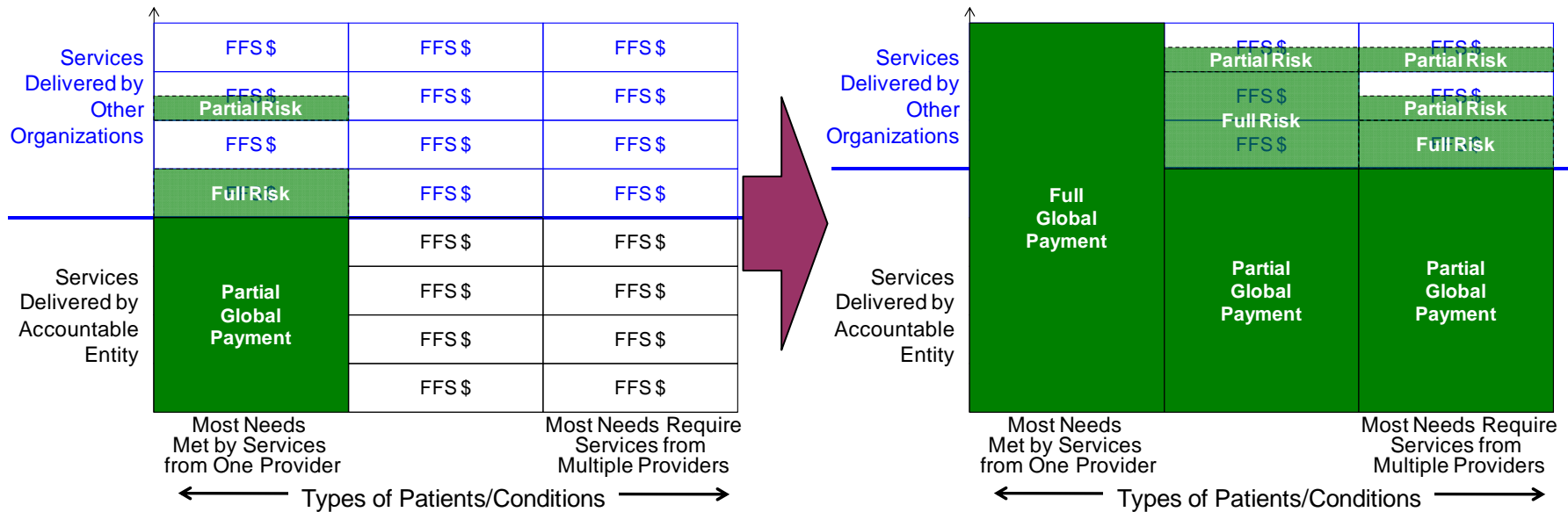
Expand to More Patients/Costs When Providers Are Capable



Continue Transition: Success Might Be Managing “Most Costs”



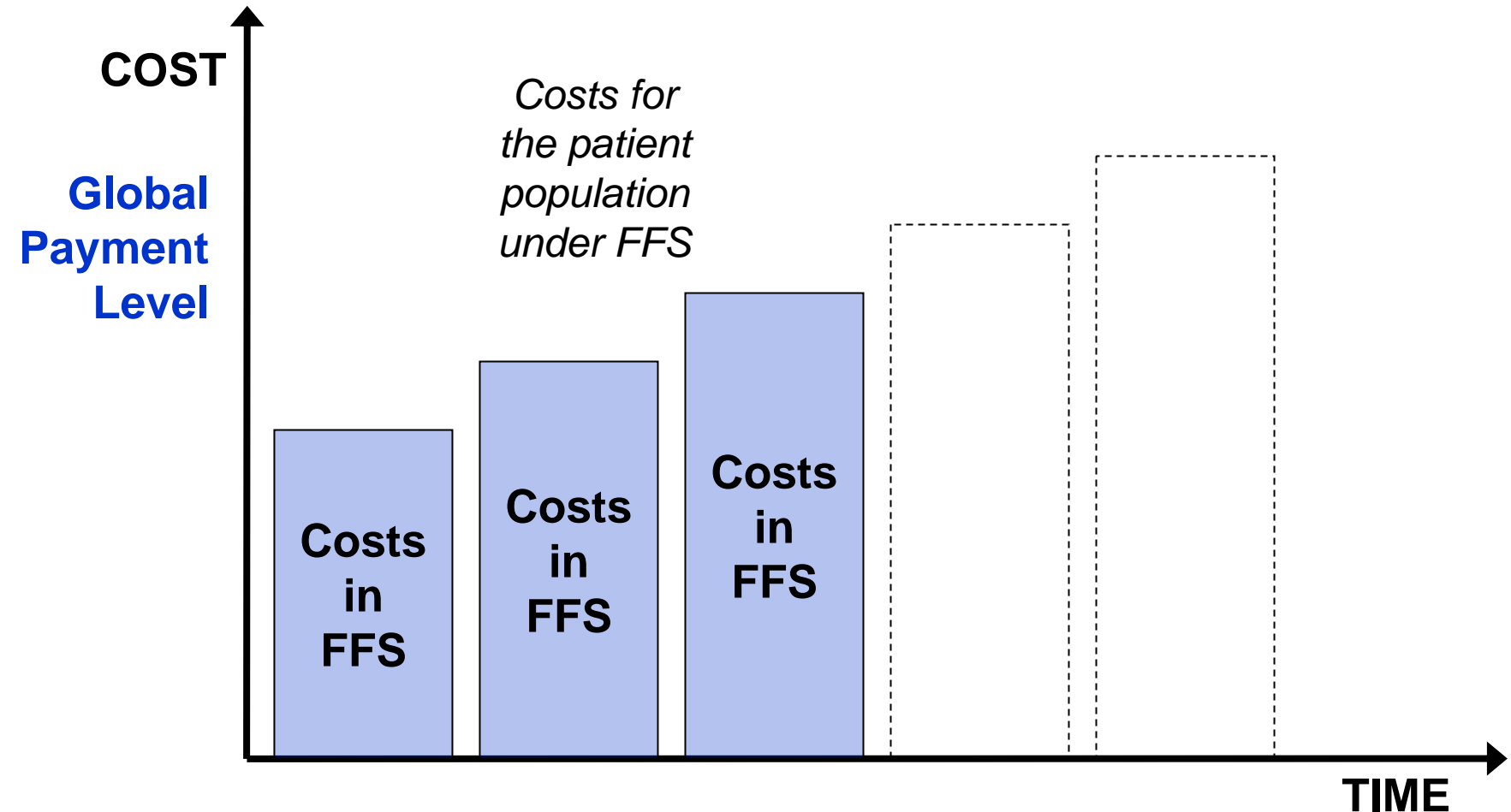
Transition Timetable May Differ From Region to Region



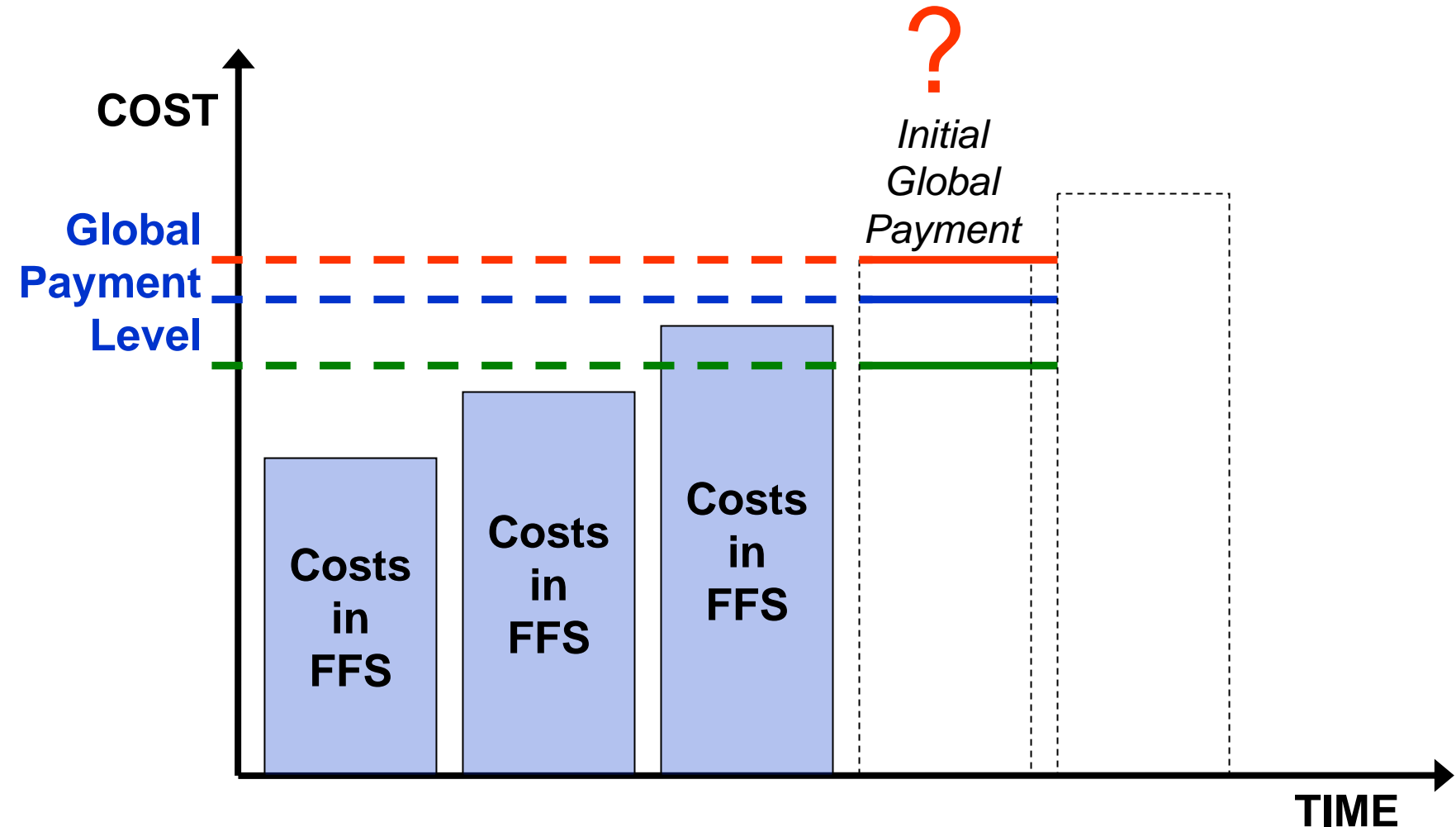
How Do You Set the Price of an Episode or Global Payment?

- If price is too high, inefficiencies will exist, regardless of what incentives may exist in the payment method
- If price is too low, providers will be unable to deliver high-quality care
- So how does the “right” price get determined?

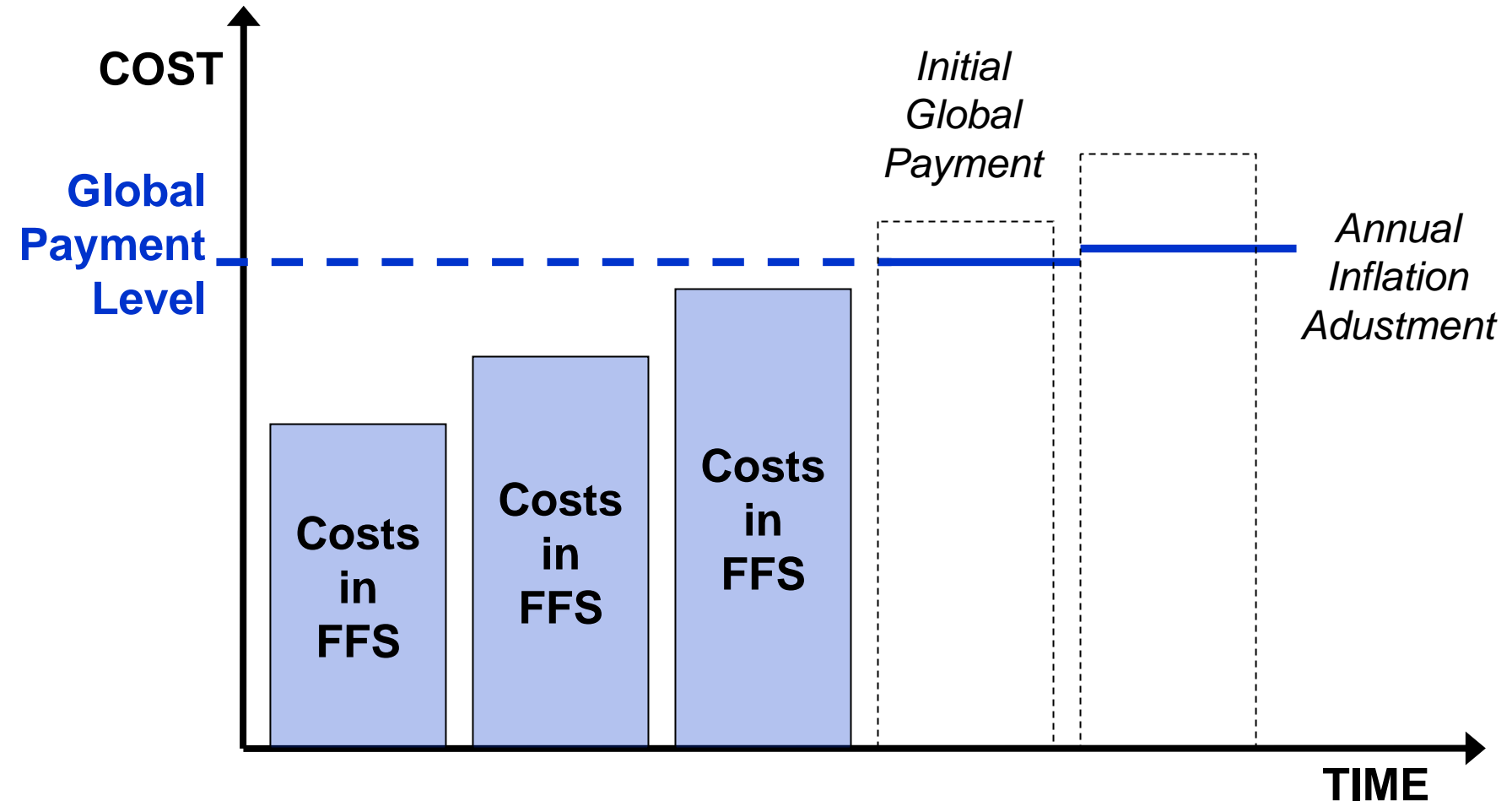
Pricing Global Payments



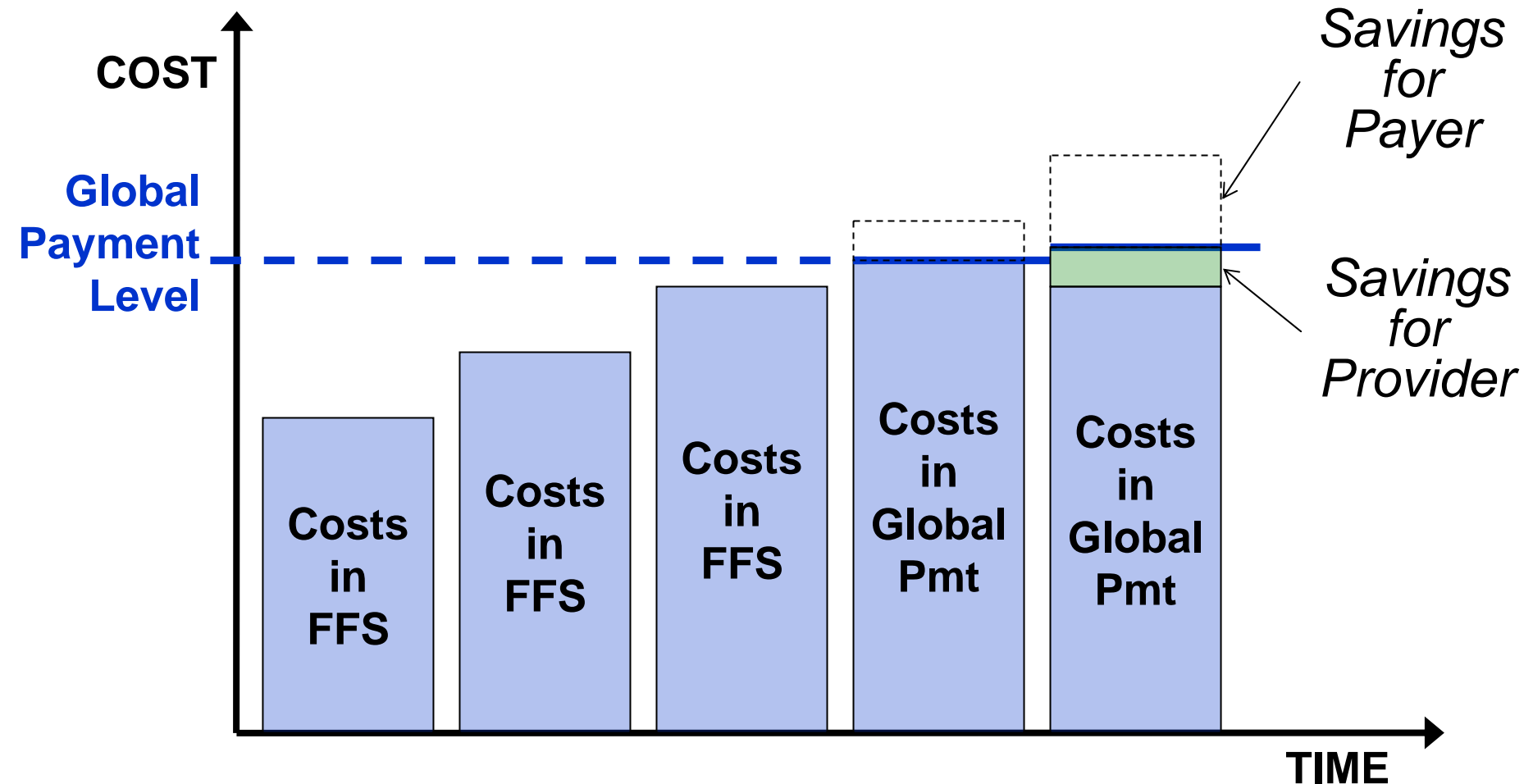
Expect Immediate Savings? Or Slowing of Growth?



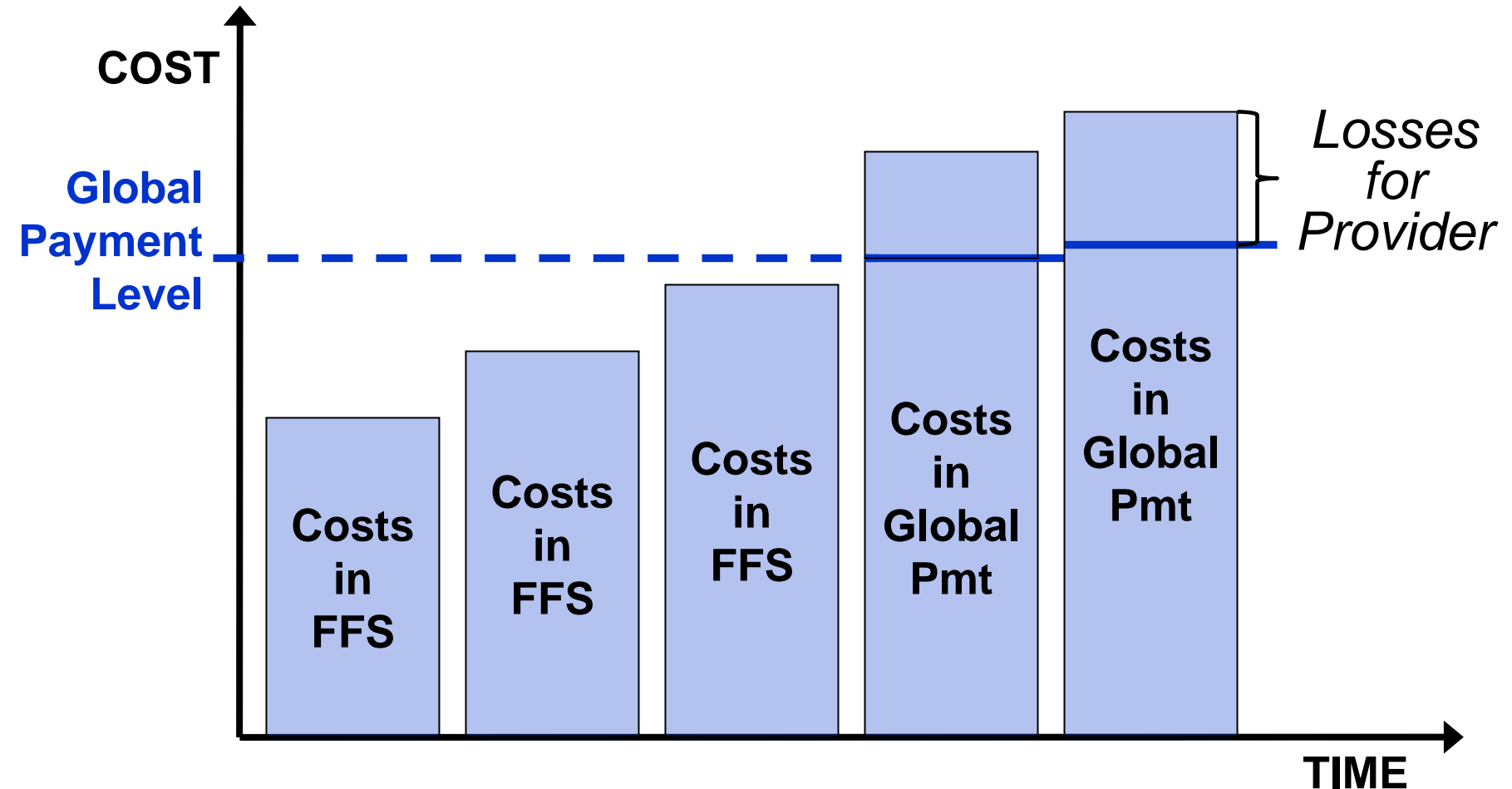
BCBSMA AQC Solution



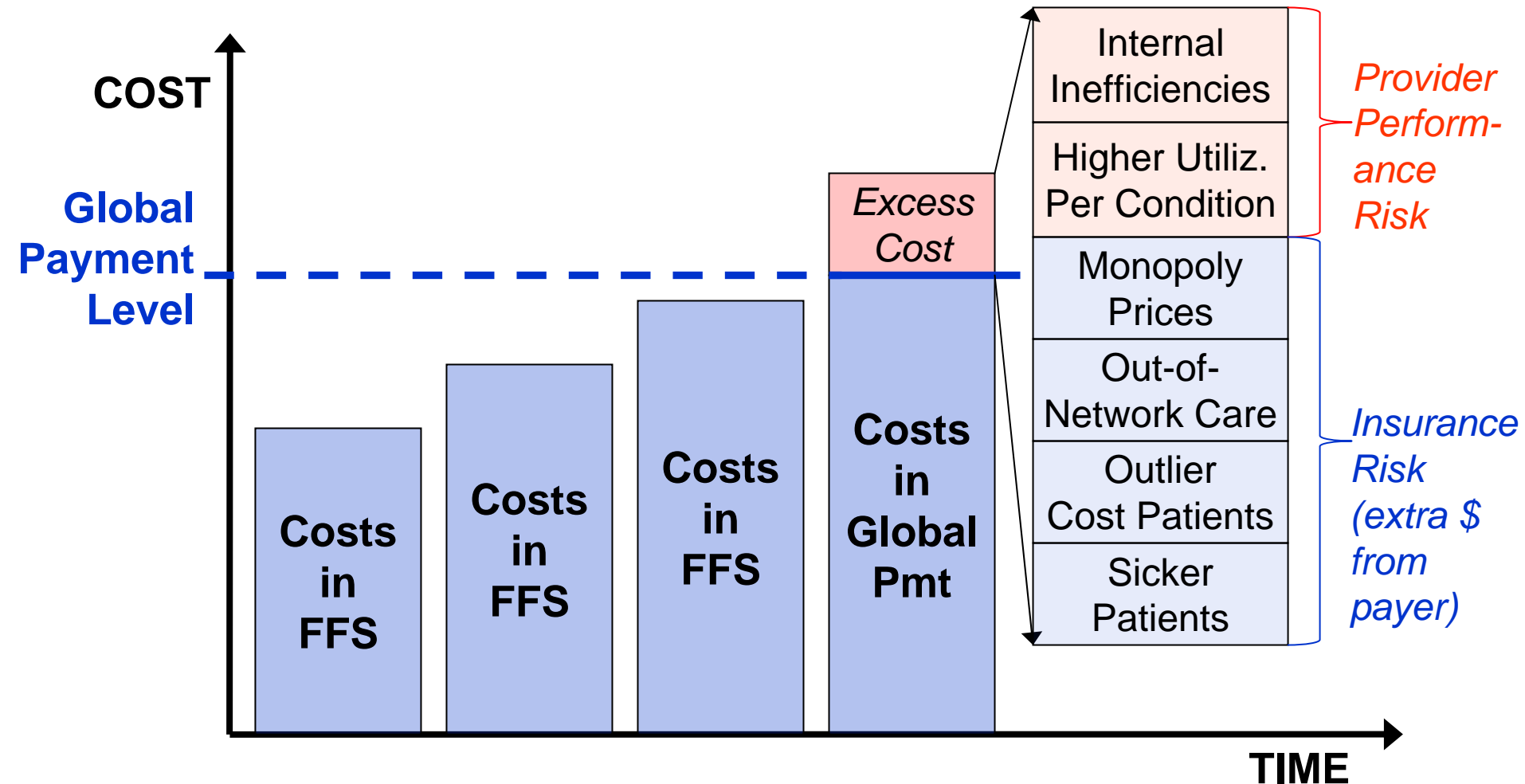
If Costs Are Controlled, Payer & Provider Both Benefit



But if Costs Continue to Increase, Provider Is at Risk



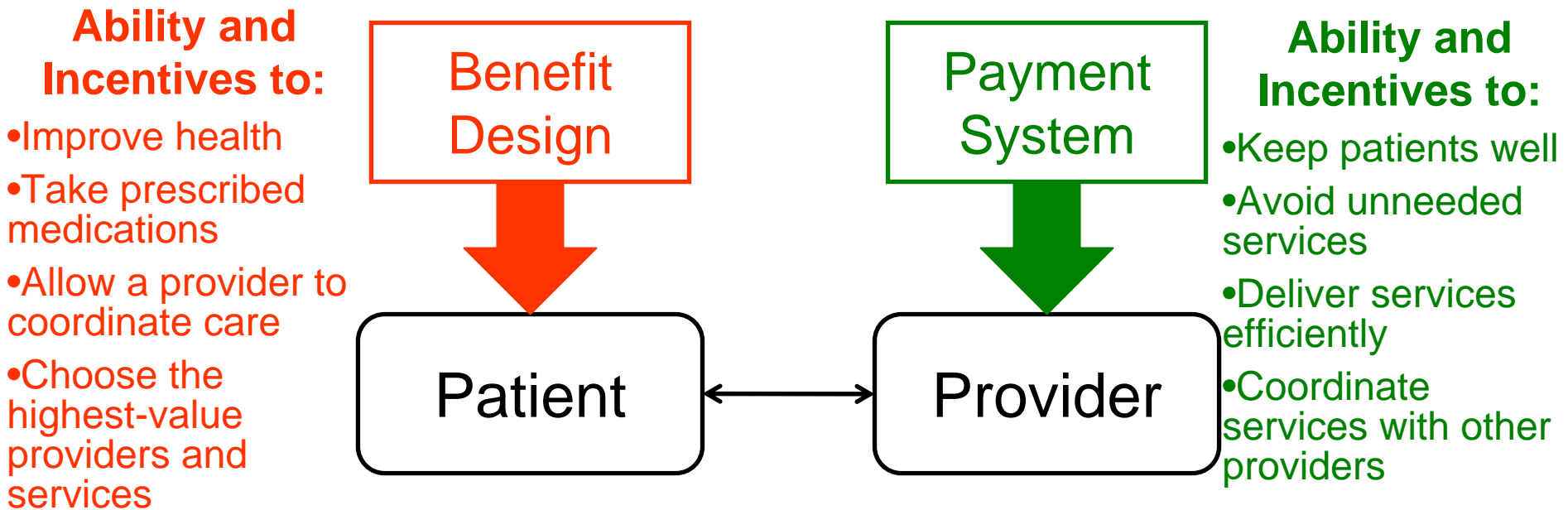
Solution: Risk Limits for Provider



Tailoring and Transitioning Risk Limits

- Different Levels of Risk for Different Types and Sizes of Providers
 - Physician groups may need tighter limits on risk initially because of lack of financial reserves
 - Smaller and non-integrated providers may need greater protection for out-of-network care
- Increasing Risk Over Time As Provider Capabilities Grow
 - Transition from fewer to more types of patients
 - Transition from fewer to more types of services
 - Transition from smaller to higher limits on risk

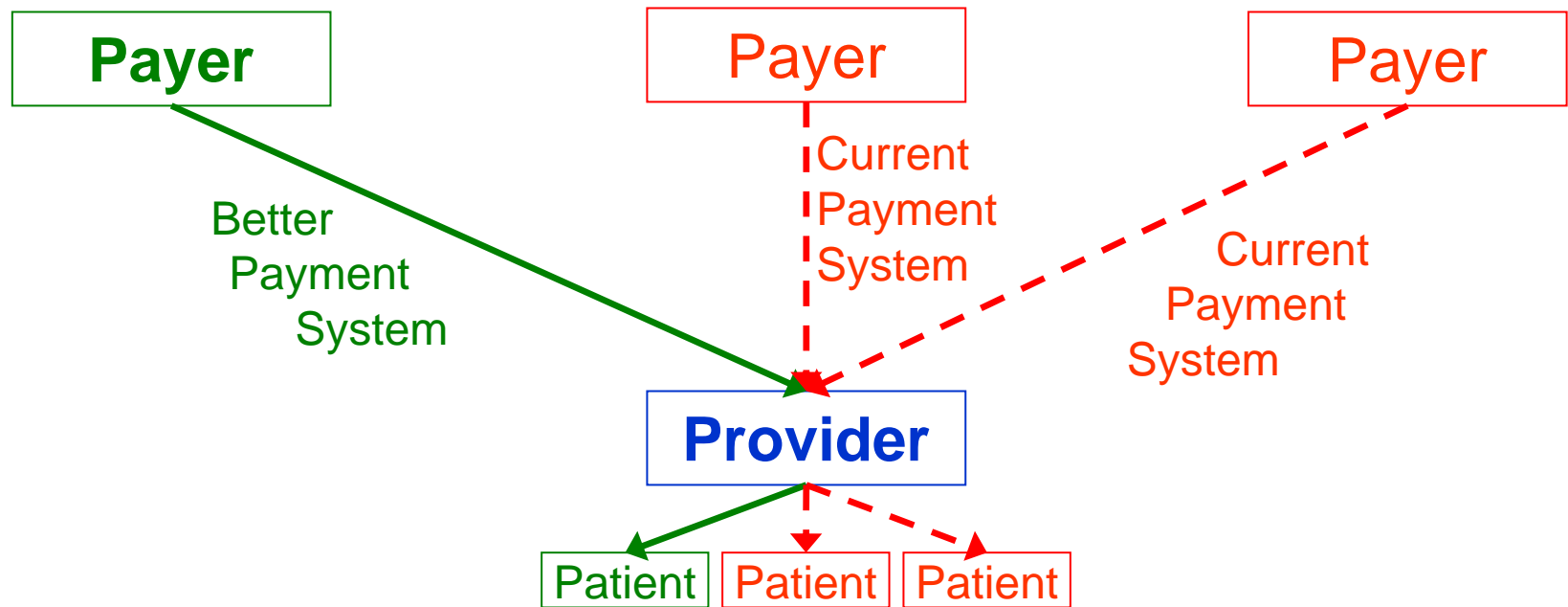
Benefit Design Changes Are Also Critical to Success



Key Issues for Benefit Design

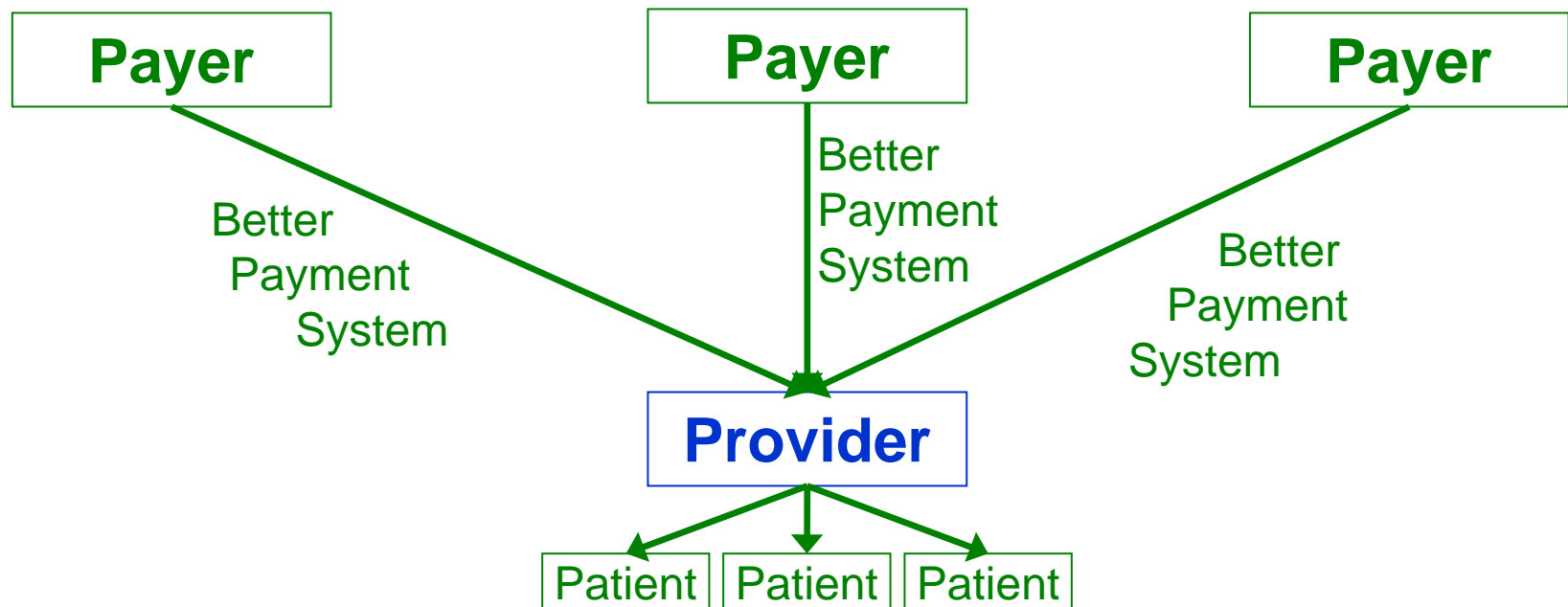
- Patients may not be able to afford the medications that will keep them well and out of the hospital
- Patients generally have little or no incentive to choose a higher-value (i.e., lower cost and high quality) *provider*
 - For the most expensive services, copays, coinsurance, and high-deductible health plans may discourage them from using the service *altogether*, but not from using the *highest-cost* provider of that service
 - Consumers need to pay the last dollar of cost (the difference in price) instead of the first dollar
- Patients generally have little or no financial incentive to choose a higher-value *treatment alternative*

One Payer Changing Isn't Enough



Provider is only compensated for changed practices for the subset of patients covered by participating payers

Payers Need to Align to Enable Providers to Transform



Major Changes In *Both* Payment & Delivery Systems Are Needed...

TODAY

Fee
for
Service

PAYMENT SYSTEM REFORM

THE FUTURE

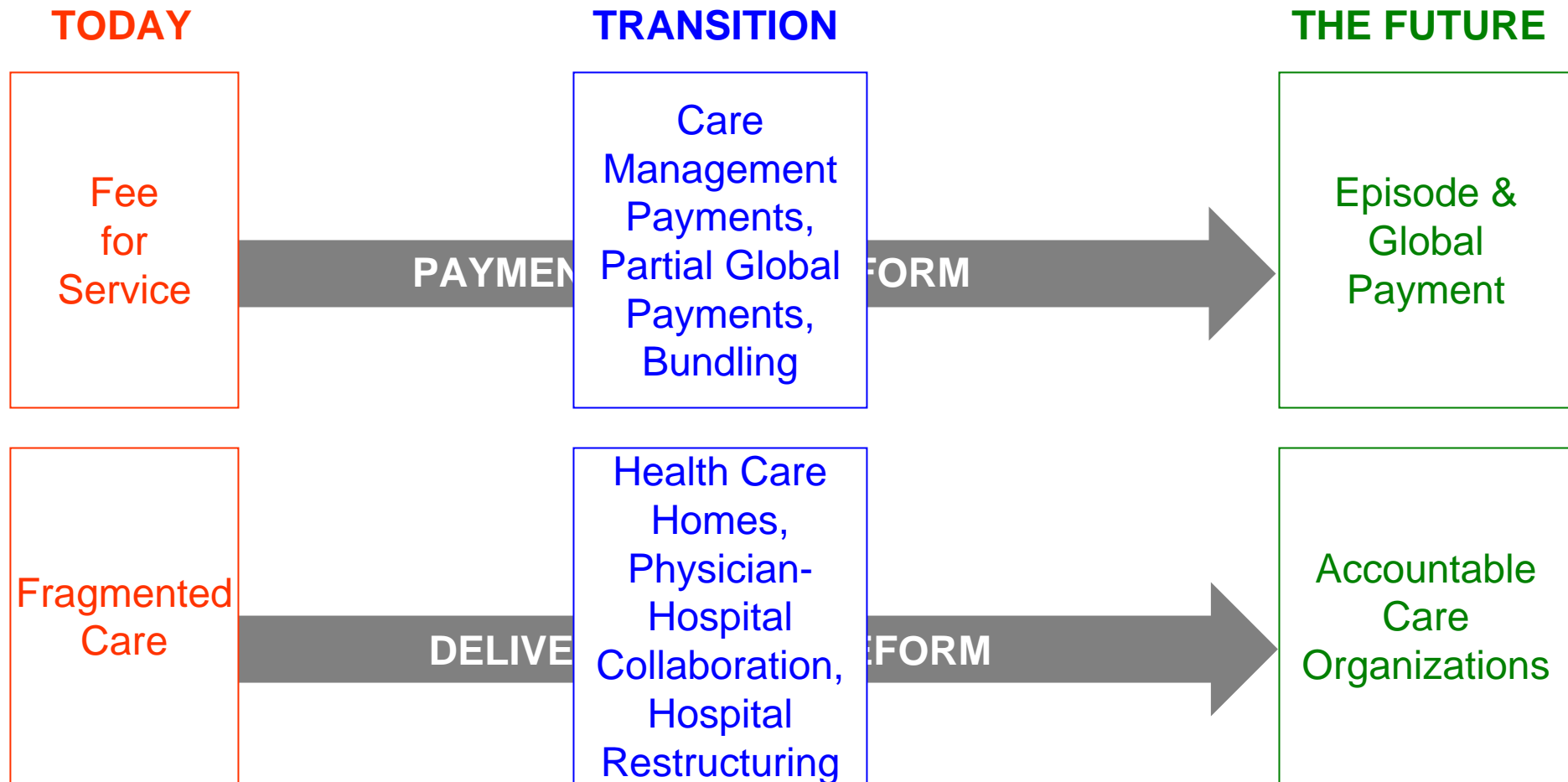
Episode &
Global
Payment

Fragmented
Care

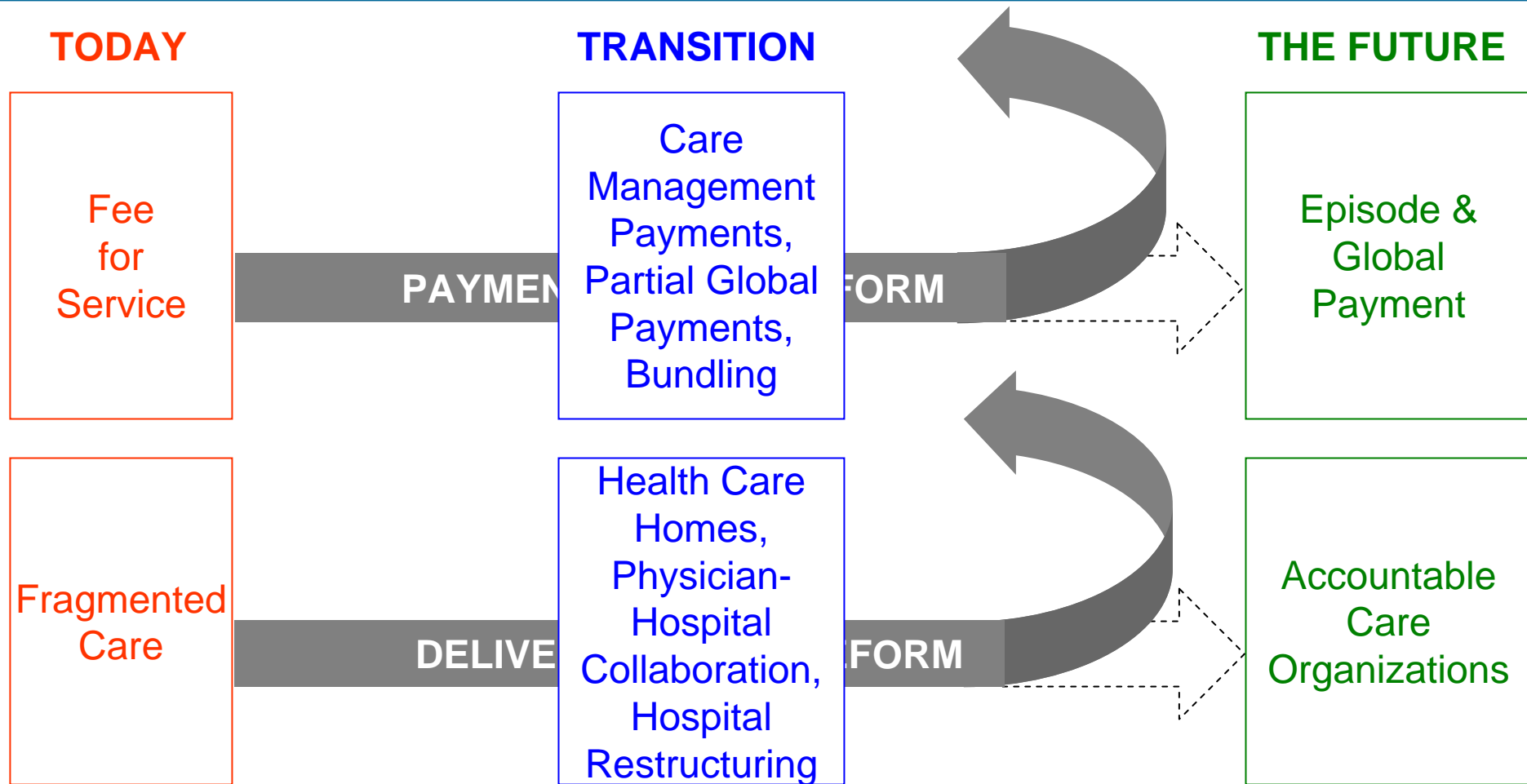
DELIVERY SYSTEM REFORM

Accountable
Care
Organizations

Transitional Steps Needed in Both Payment & Delivery Systems



Retain a Focus on the Ultimate Goal to Stay on the Right Road



For More Information:

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(412) 803-3650

www.CHQPR.org
www.NRHI.org
www.PaymentReform.org

Issues for the Payment Reform Breakout

- Which types of cost increases should providers be responsible for and which should payers retain responsibility for?
 - E.g., costs of out-of-network providers, outlier patients, newly attributed patients, etc.
- How should greater accountability for costs and outcomes be phased in over time? Should different providers be permitted to accept different levels of accountability?
- Which types of changes need to be made to the existing FFS structure where it continues to be used?
 - E.g., payment for currently unreimbursed services, care management payments for PCPs, etc.
- Which elements of payment systems need to be identical across all payers? How much variation across payers is feasible for providers and desirable for innovation?
 - Payment method, risk adjustment, patient attribution, quality measures?

Issues for the Benefit Design Breakout

- What requirements/incentives should health plan members have to choose & consistently use a health care home/ACO?
 - E.g., lower or no copays for visits to health care home, lower co-insurance for use of specialists with referral from health care home, etc.
- What requirements or incentives should consumers have to choose lower-cost, higher-value providers? How much should location/convenience of service and consumer satisfaction with providers override cost differentials?
- What requirements or incentives should consumers have to choose lower-cost, higher-value services depending on what clinical guidelines recommend (if guidelines exist)?
- How should pharmacy benefits support ACOs?
 - E.g., low/no-copays for chronic disease medications (including brand names), income-based copays, ACO-defined pharmacy benefits

Issues for the ACO Qualifications Breakout

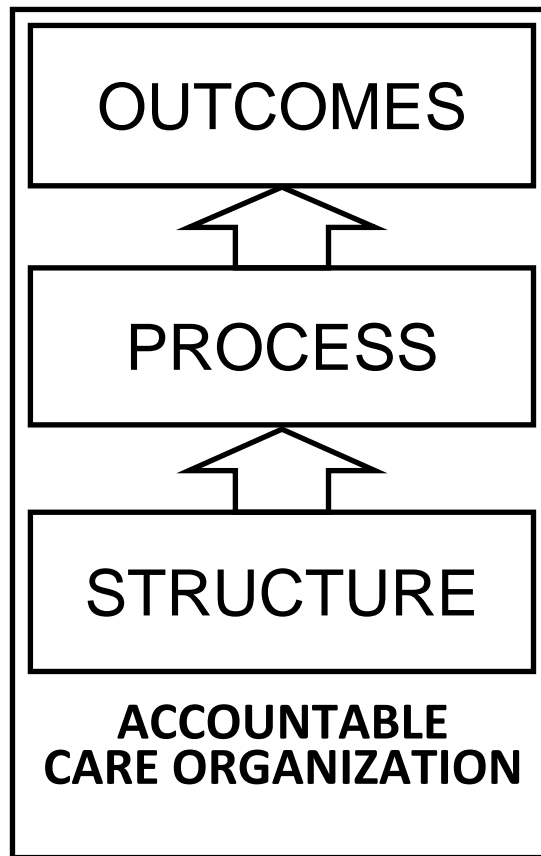
- Should there be different “levels” of ACO, with different capabilities and different eligibility for payment flexibility/rewards? Should there be transitional levels of ACO certification, to reflect evolving capabilities of providers?
- What capabilities must individual providers in an ACO meet?
 - E.g., certification/accreditation of PCPs as health care homes
 - E.g., minimum quality standards, minimum levels of efficiency
 - E.g., financial reserves to cover variations in cost
- Which providers, if any, must exclusively associate with a single ACO?
 - E.g., primary care physicians, specialists, hospitals
- Which providers must be part of or contractually affiliated with a provider in order for it to be considered as an ACO?
 - E.g., providers delivering majority of services to be managed by ACO

Issues for Quality Measurement/ Improvement Breakout

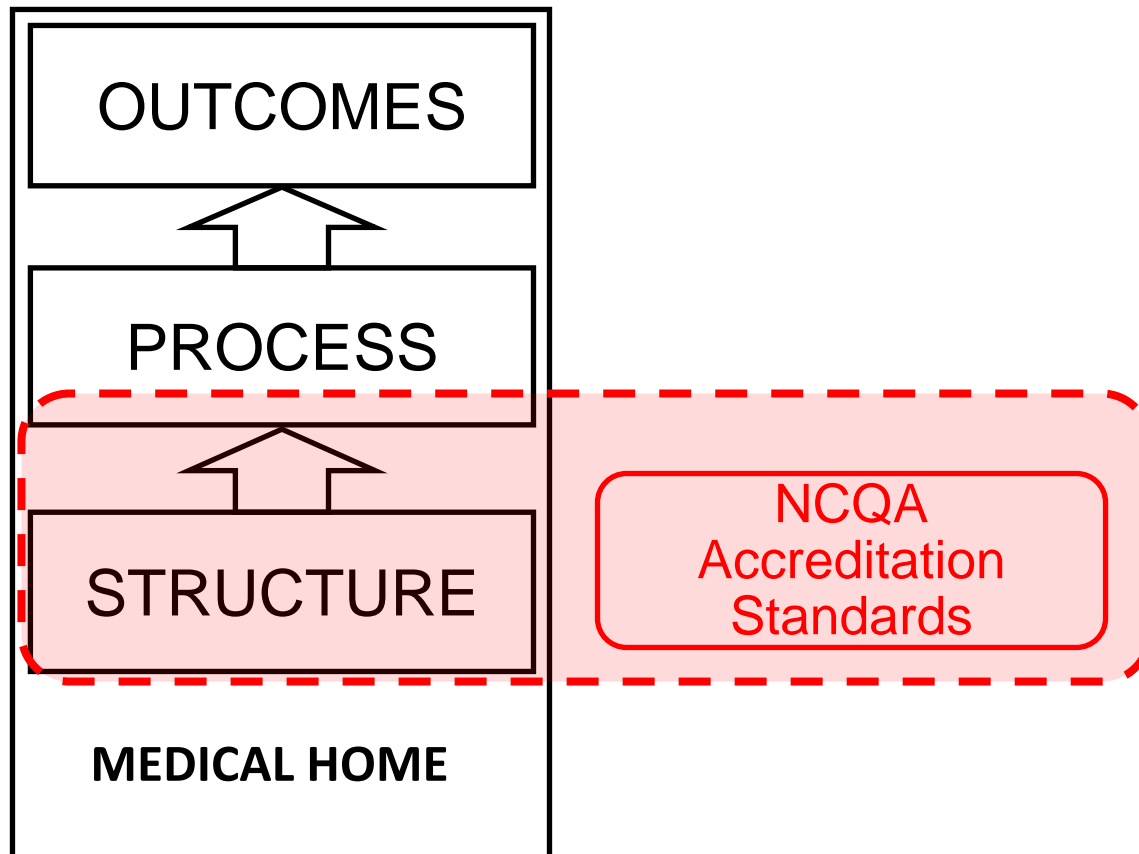
- Which measures of quality are most important for protecting consumers, particularly disadvantaged populations?
- What are the biggest gaps in current quality measurement systems? How should these gaps be addressed?
- Should all measures be publicly reported? Should all measures be used to modify payment through bonuses and penalties?
- Which current measures, if any, should be modified or replaced?
- How timely must quality measures be to enable providers to improve/address problems, and for payers/regulators to identify and address problems? How can this timeliness be ensured?

APPENDIX

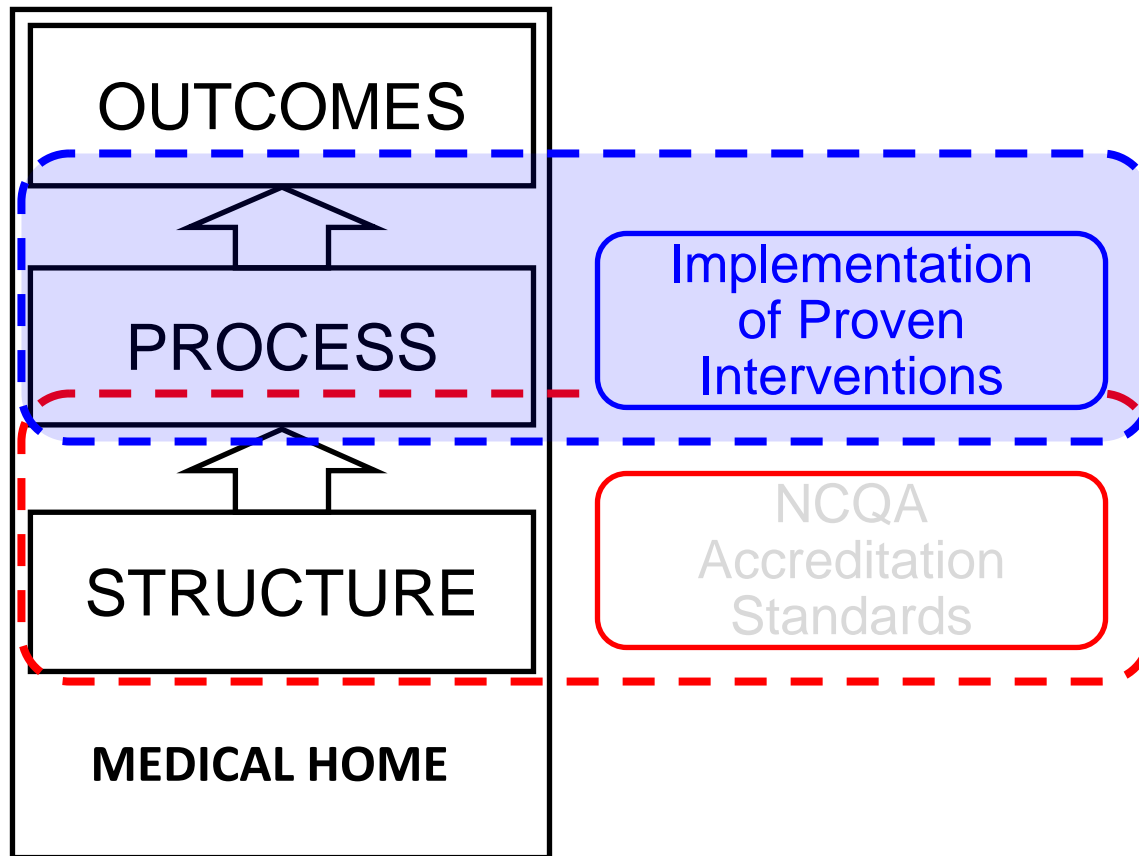
What Should Be Required for a Provider to be an ACO?



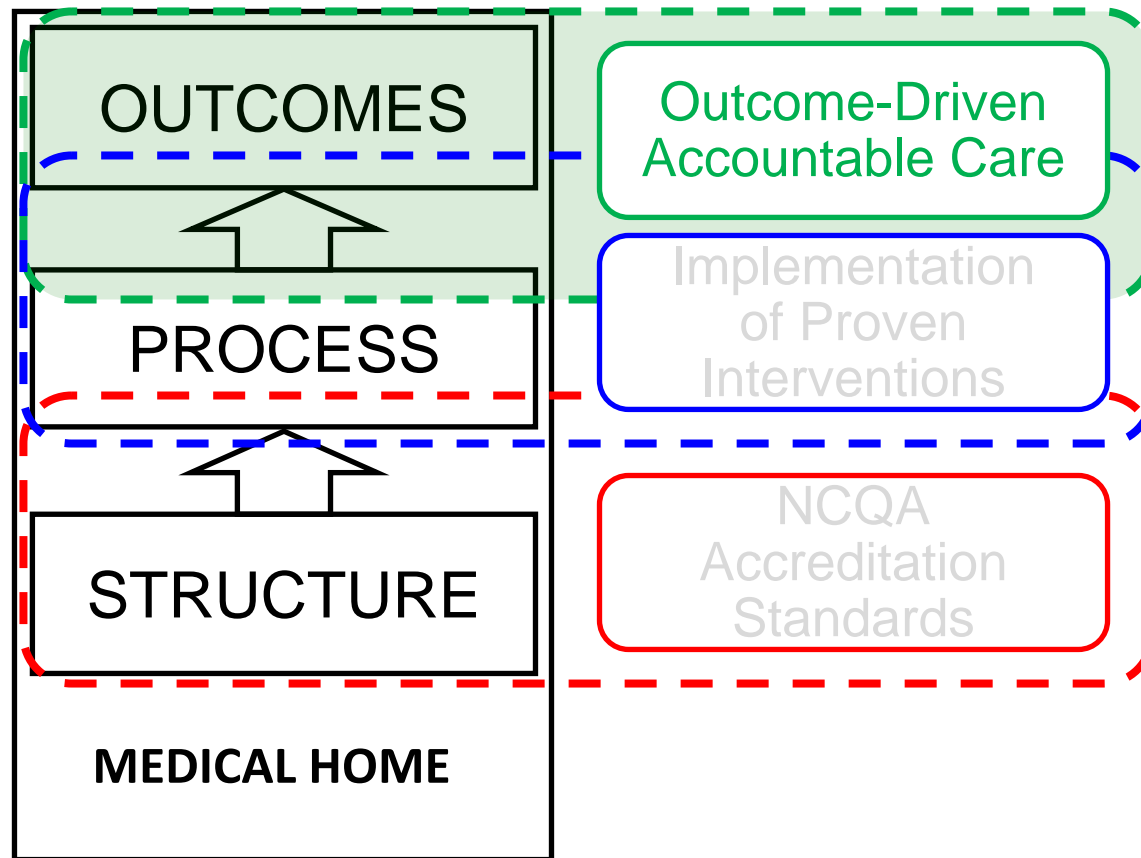
Evolution of Medical Home Requirements, Phase 1



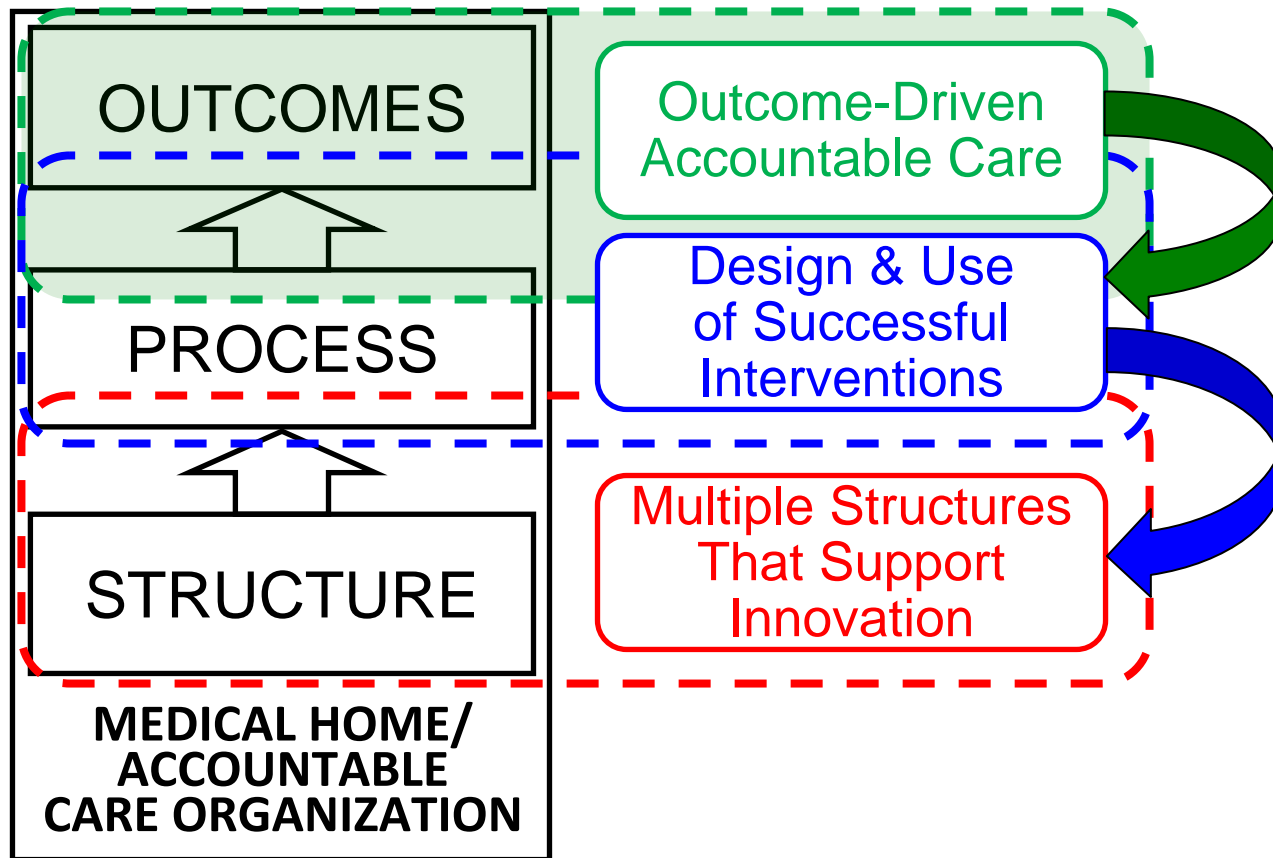
Evolution of Medical Home Requirements, Phase 2



nrhi Requirements, Phase 3 (hopefully)



Outcomes Should Drive the Processes and Structures



APPENDIX

Our Standard Methods of Controlling Prices Don't Work

- **Price Negotiations as Part of Contracting**
 - Even large insurers can't demand price concessions from large/monopoly providers

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- **Copays, Co-insurance and High-Deductible Health Plans**
 - Create little incentive for consumers to choose lower-cost providers on the expensive items that make a difference
 - Create significant disincentive to pursue preventive care that may prevent the expensive items in the first place

Your Choices With Auto Purchase Insurance

HYUNDAI SONATA



5 yr/60,000m warranty
5 star crash rating

MSRP: \$22,450

LEXUS LS 460



4 yr/50,000m warranty
No crash rating

MSRP: \$63,825

Copayment: Lexus Wins

HYUNDAI SONATA



5 yr/60,000m warranty
5 star crash rating

MSRP: \$22,450

\$1,000 Copay:

\$1,000

LEXUS LS 460



4 yr/50,000m warranty
No crash rating

MSRP: \$63,825

\$1,000✓

Coinsurance: Lexus Wins for Most People

HYUNDAI SONATA



5 yr/60,000m warranty
5 star crash rating

MSRP: \$22,450

\$1,000 Copay: **\$1,000**

10% Coinsurance: **\$2,245**

LEXUS LS 460



4 yr/50,000m warranty
No crash rating

MSRP: \$63,825

\$1,000 ✓

\$6,383 ✓

High Deductible: Lexus Wins

HYUNDAI SONATA



5 yr/60,000m warranty
5 star crash rating

MSRP: \$22,450

\$1,000 Copay: **\$1,000**

10% Coinsurance: **\$2,245**

High Deductible: **\$10,000**

LEXUS LS 460



4 yr/50,000m warranty
No crash rating

MSRP: \$63,825

\$1,000 ✓

\$6,383 ✓

\$10,000 ✓

Price Difference: Hyundai Wins for Most People

HYUNDAI SONATA



5 yr/60,000m warranty
5 star crash rating

MSRP: \$22,450

LEXUS LS 460



4 yr/50,000m warranty
No crash rating

MSRP: \$63,825

\$1,000 Copay:

\$1,000

\$1,000 ✓

10% Coinsurance:

\$2,245

\$6,383 ✓

High Deductible:

\$10,000

\$10,000 ✓

Price Difference:

\$0 ✓

\$41,375

Better Ways of Controlling Prices

- **Value-Based Competition by Providers for Consumers**
 - Define episode prices and global fees so it's easier to compare costs of different providers and procedures
 - Publish information on prices and quality of all providers
 - Require consumers to pay the “last dollar” of providers’ prices (i.e., the difference between the prices of more expensive and less expensive providers/services with equivalent quality)
 - Create shared decision-making processes to help consumers decide among services based on benefits and costs

Better Ways of Controlling Prices

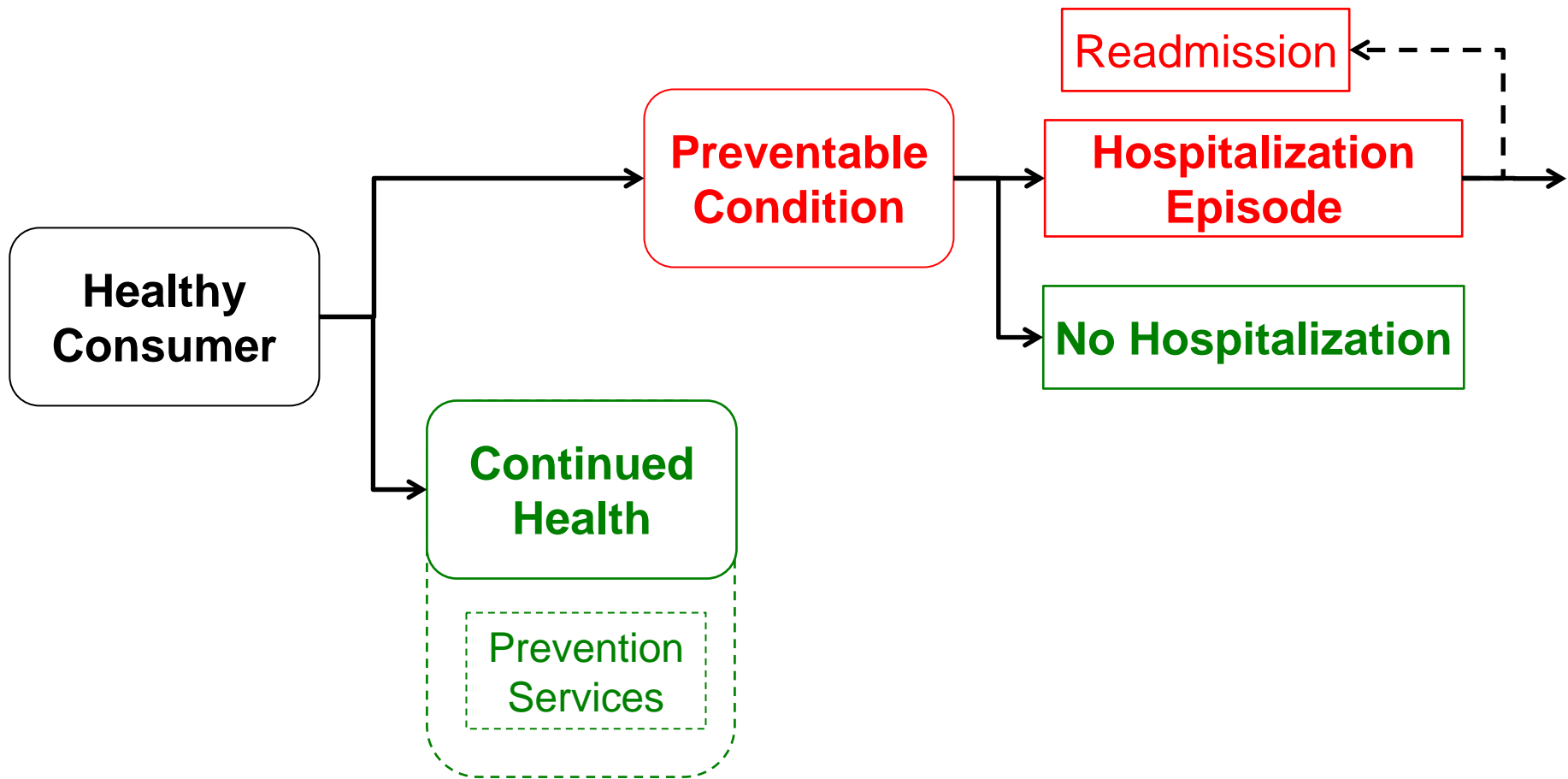
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- **Ensuring There Are Competitors**
 - Prevent anti-competitive consolidations and encourage limited duplication of services (assuming consumers are made price-sensitive)
 - Regulate prices where monopolies exist (e.g., the Maryland Hospital rate-setting commission)
 - Prohibit all-or-nothing contracting for services by large health providers as a condition of tax exemption

APPENDIX

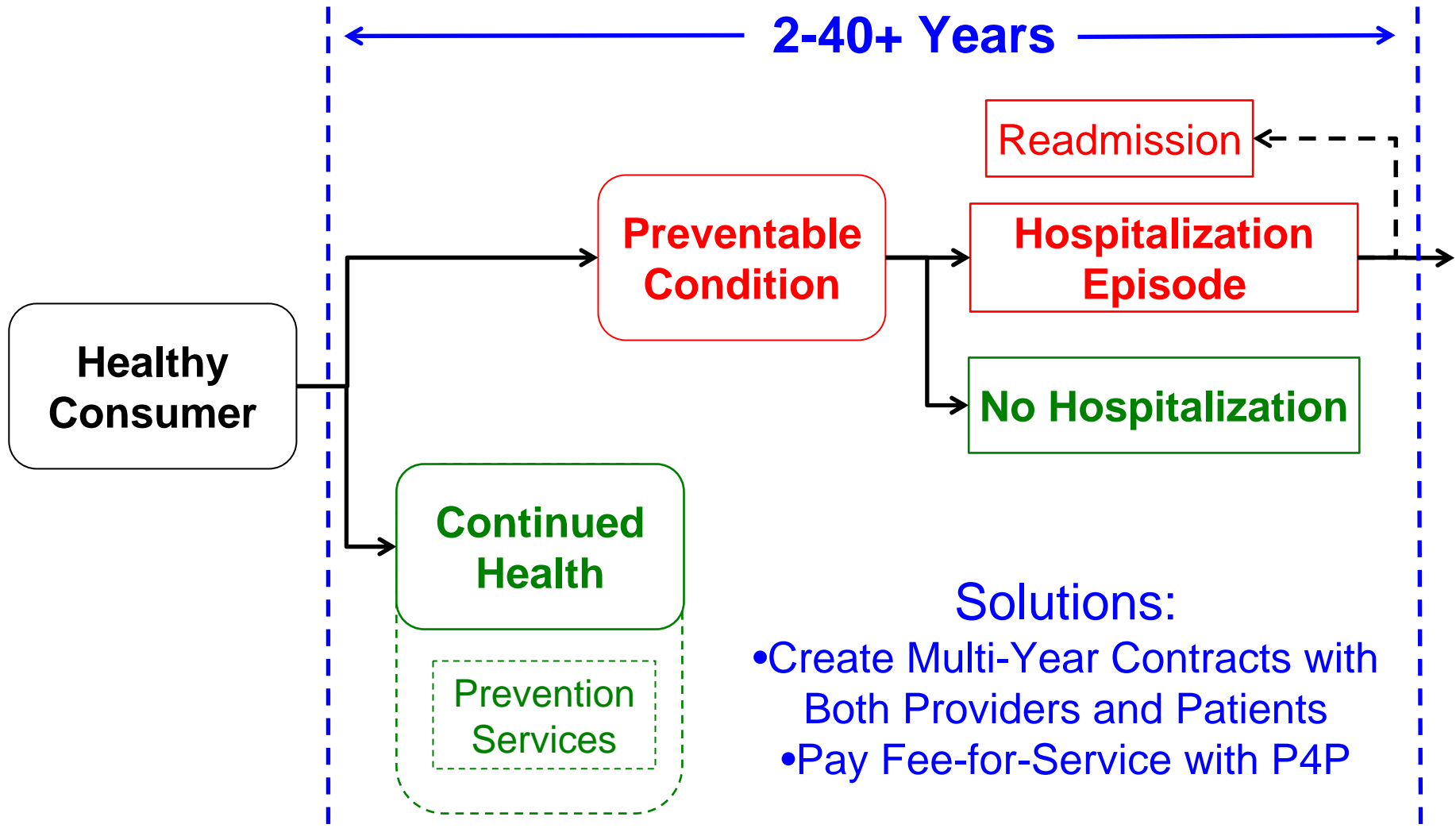
Better Payment Systems Require Good Quality Measurement

- Concern: Giving healthcare providers more accountability for costs reduces the incentives for overuse, but raises concerns about whether patients will get too little care

Biggest Challenge: Incenting Primary Prevention



Problem: ROI Occurs Beyond Life of Provider Contracts & Benefits



Solutions:

- Create Multi-Year Contracts with Both Providers and Patients
- Pay Fee-for-Service with P4P

Better Payment Systems Require Good Quality Measurement

- **Concern:** Giving healthcare providers more accountability for costs reduces the incentives for overuse, but raises concerns about whether patients will get too little care
- **Solution:** Measure healthcare quality and include incentives for providers to maintain/improve quality as well as reduce costs

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- **Concern:** Giving healthcare providers more accountability for costs reduces the incentives for overuse, but raises concerns about whether patients will get too little care
- **Solution:** Measure healthcare quality and include incentives for providers to maintain/improve quality as well as reduce costs
- **Ideal:** Develop quality measures *with participation of providers*, as Minnesota already does

