



Quality → Accountable Care → Population Health: The Journey Continues

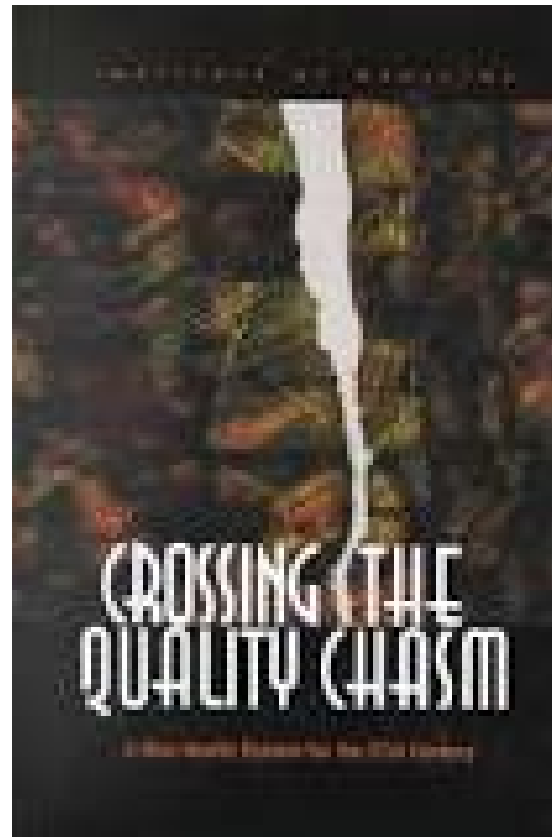
Health Insights

April 10, 2014

Doug Hastings

2001

Institute of Medicine



An Agenda For Crossing The Chasm

- “Between the health care we have and the care we could have lies not just a gap, but a chasm. The need for leadership in health care has never been greater.”
- “Health care should be safe, effective, efficient, patient-centered, timely, and equitable.”
- “What is perhaps most disturbing is the absence of real progress toward restructuring health care systems to address both quality and cost concerns, or toward applying advances in information technology to improve administrative and clinical processes.”

Source: The *Chasm* report

2010

One Hundred Eleventh Congress of the United States of America

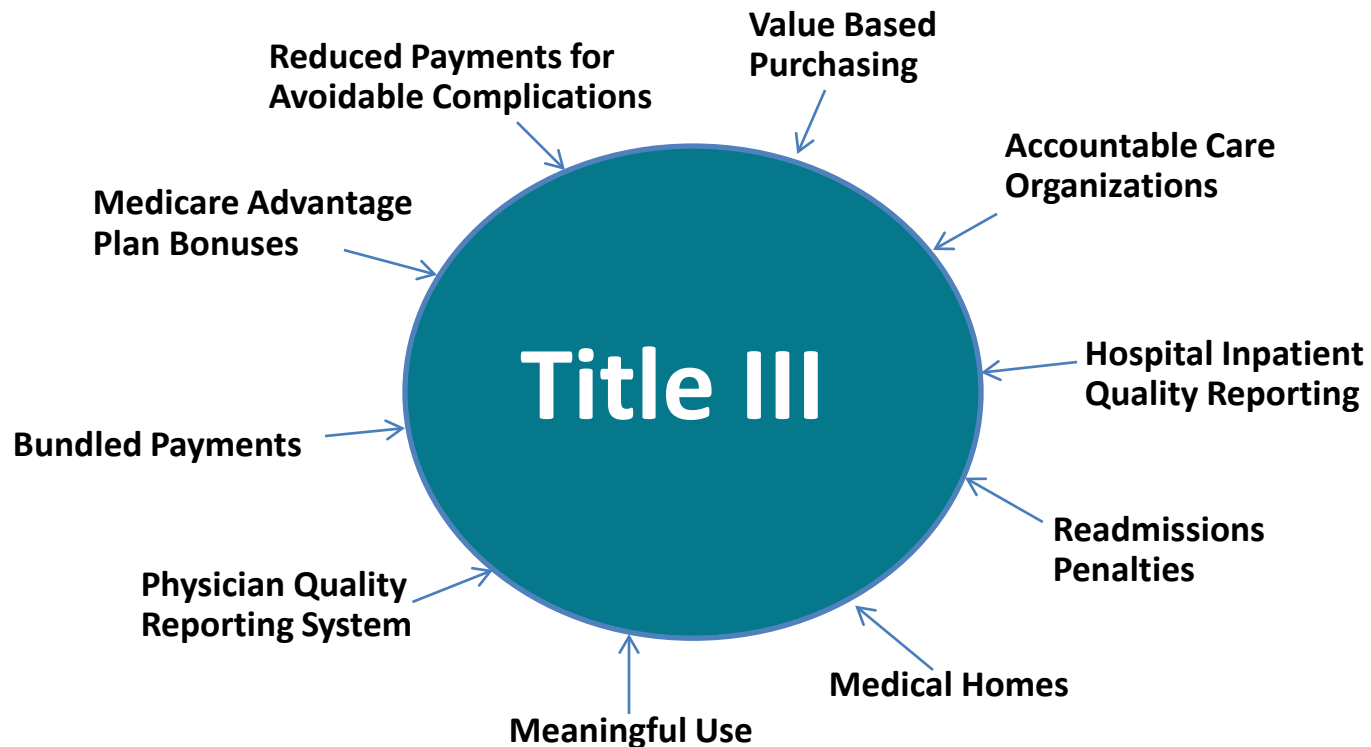
AT THE SECOND SESSION

*Begun and held at the City of Washington on Tuesday,
the fifth day of January, two thousand and ten*

An Act

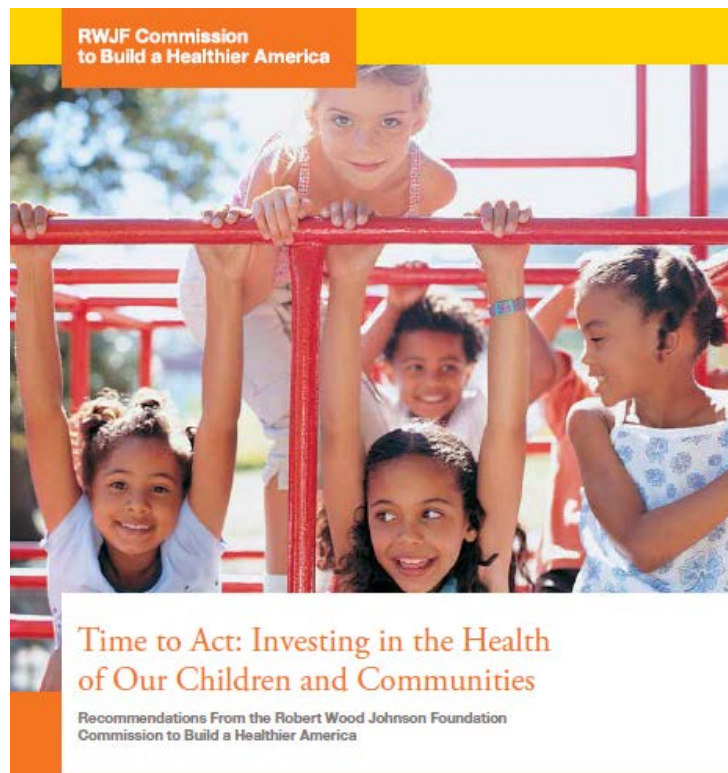
Entitled The Patient Protection and Affordable Care Act.

The Affordable Care Act



2014

Robert Wood Johnson Foundation



Report Issued By Committee Led By Economists Mark McClellan and Alice Rivlin

- Our nation is unhealthy, and it is costing us all through poorer quality of life and lost productivity. Health in America is worse than in other developed nations on more than 100 measures
- To become healthier and reduce the growth of spending on both public and private medical care, we must create a **seismic shift** in how we approach health and the actions we take
- As a country, we need to expand our focus to address how to stay healthy in the first place
- This will take a revolution in the mindset of individuals, community planners and leaders, and health professionals
- It will take new perspectives, actors, and policies, and will require seamless integration and coordination of a range of sectors and their work
- This shift is critical for both the health and economic well-being of our country

The Population Health Business Case

- Saves billions of dollars; potential return to payers, providers, and consumers
- Reduces the cost of coverage for all
- Creates opportunities for new products and services for multiple customer segments
- Enhances employee productivity
- Strengthens families and children, enabling greater educational, employment, and consumer contributions to the economy

The Path to Continuously Learning Health Care in America

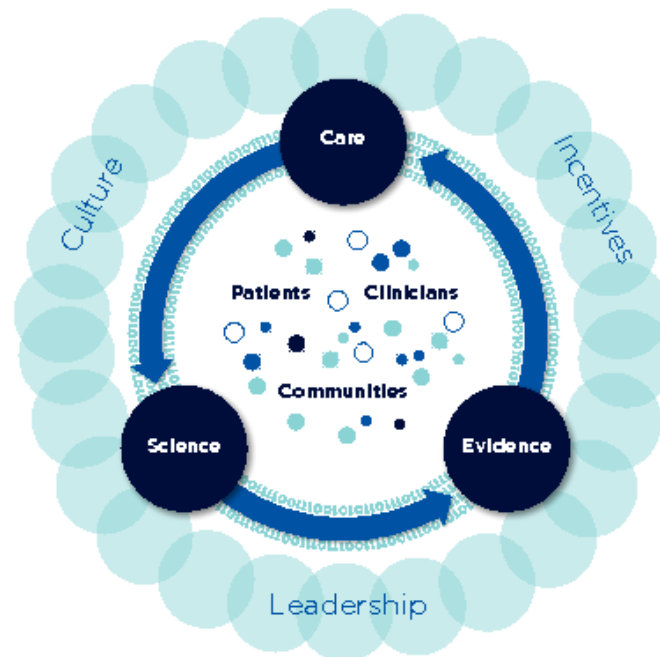


FIGURE S-3 Schematic of the continuously learning health care system.


Source: The Institute of Medicine

Health Policy at a Fork in the Road

**Benefit and Price
Reduction**

OR

**Fundamental Delivery
System Reform**



Regardless of how you envision the role of government, health care and the markets in which it's purchased need to be improved

Source: The Commonwealth Fund 10

Policy Drivers, 2014

- Policy influencers believe that the first phase of accountable care change is already over; transformation to payment for value will accelerate, not slow down
- CMS is doubling down on reducing readmissions and post-acute costs
- A recently-published IOM study blames post-acute costs as the principal source of variation in Medicare spending and provider pricing as the principal source of variation in commercial spending
- Experienced ACO providers are pushing to get to full risk fast; they believe that they can't sustain a transformed delivery system with shared savings only
- Lawmakers and regulators are beginning to understand the high cost of an unhealthy population
- Coordination vs. competition remains a hot-button issue

Will Shared-Savings ACO Arrangements Generate Enough Revenue for Hospitals to Offset Lost Utilization?

“For a period of time, most hospitals and health systems will be managing the difficult balance of being paid a mixture of fee-for-service and value-based payments. Their ability to influence the pace of change and stay balanced while investing for the future will determine their success.

Shared savings likely is not a long-term model. Nor is traditional “market share” growth alone, given antitrust constraints and changing markets. What may be sustainable is a carefully-executed shift by hospitals and health systems over time to providing high value health care (which by definition includes lower costs and incentives to keep patients healthy) to designated populations on a global fee or capitated basis.”

Source: Doug Hastings, *Accountable Care News*, November 2013

Leavitt ACO Update, 2014

- Nearly 200 new Medicare and commercial ACOs formed in 2013 (definition requires contracts that involves defined population and/or risk)
- Over 600 ACOs total now in operation, covering over 18 million lives
- More than 350 Medicare ACOs, and 250 commercial ACOs
- Majority of Medicare ACOs are physician-owned
- There are ACOs in all 50 states, with California, Florida and Texas having the most; over 500 of the 600+ operate in only one state
- Major insurers have set goal of 50% of their books of business in ACOs by 2015 (hundreds of new ACOs)

Preliminary Medicare ACO Results

- Over 360 Medicare ACOs serving up to 5.3 million people
- Costs for beneficiaries aligned to “Pioneer ACOs” increased only 0.3 percent in 2012 vs. 0.8 percent for other beneficiaries
- Over \$380 million in savings have been generated by Medicare ACOs and Pioneer ACOs
- 9 out of 23 Pioneer ACOs produced gross savings of \$147 million in their first year
- All but 5 of the 114 participants “satisfactorily reported” quality measures

Source: The Commonwealth Fund; ACO Learning Network

Early Commercial ACO Results – A Few Examples

- Under the Advocate-Blue Cross agreement in Illinois, hospital admissions are down 6 percent. Days spent in the hospital are down nearly 9 percent. The average length of a stay has declined... So far, Advocate has achieved a small but significant savings of about 2 percent below projected costs
- Mission Point is up to 50,000 members in its ACO and has cut medical costs each year for its 15,000 original members by 12 percent. It also added new services, and expanded its telehealth component from one to 44 sites to capture the population residing in the rural area around metro Nashville
- Nova Health ACO (Maine) – 2012, 50% reduction in inpatient days; 45% lower admissions; 56% fewer readmissions

Early Commercial ACO Results – A Few Examples

- NewHealth Collaborative (Summa Health System) lowered its costs by 8.4 percent in its first year as a Medicare Advantage ACO, largely because of reduced hospital use, including a 10 percent reduction in readmissions
- Bon Secours in Virginia (9 hospitals) produced a \$7 million rebate to its employee health plan resulting from its ACO program for employees.
- The Accountable Care Alliance and Nebraska Medical Center found that costs for enrollees in their population management program rose just 4.2 percent over the past five years, compared with 27.4 percent nationally

ACO Implementation Challenges

- Proliferation and uncertainty of quality measures
- Obtaining comprehensive clinical and claims data
- Attribution methodologies
- Risk adjustment
- Physician and patient resistance
- Lack of payer partners
- Narrow networks
- The medical system/social service divide

Other Payment and Delivery Reform Initiatives

- About ½ of states have structured Medicaid ACO programs or initiatives
- More than 450 CMMI bundled payment initiative participants involving 50,000 health care providers
- 43 states have adopted policies and programs to advance medical homes; over 6,000 medical practices have received NCQA recognition as patient-centered medical homes
- Medicare 30-day, all-condition hospital readmissions rate trending down since mid-2010
- 93% of hospitals enrolled in meaningful use program; more than half of all physicians and other eligible providers have received incentive payments
- 107 organizations receiving funding from CMMI through Health Care Innovations Awards Round One
- 21 state legislatures are considering bills related to health disparities in 2014

Achieving Economies of Scale

- Aggregation does not equal accountability, but it is widely acknowledged that some size and scale is necessary to succeed under changing reimbursement models
- Need to be of sufficient size to support comprehensive performance measurement, cost savings and expenditure projections
- Need to be able to manage the continuum of care for a defined population
- Need capital to make infrastructure investments needed to achieve integration (care redesign, information technology)
- Both change of control transactions and non-change of control collaborations are taking place in large numbers all across the country, including for-profit/non-profit deals

Coordinated Federal Agency Guidance for Accountable Care Organizations

- The regulatory dialogue that has taken place around accountable care seeks to distinguish “good” collaboration from “bad” and relies heavily on clinical and financial integration as a basis for allowable collaborations
- The guidance taken together suggests that qualified and effectively operating ACOs do gain a degree of legal protection (arguably, a rebuttable presumption) under these regulatory schemes through waivers, safety zones, and announced agency protocols
- CMS’ definition of and requirements for ACOs align with the Antitrust Agencies’ historical thinking about clinical and financial integration, and therefore will accord rule of reason treatment to the commercial market activities of ACOs participating in the MSSP market share

Antitrust: Market Power Issues

- Market share and market power concerns remain the subject of an ongoing national policy debate
- DOJ and FTC clearly state that they will continue to protect competition in markets served by ACOs, using CMS data, and will “vigorously monitor complaints.” And merger enforcement is not affected – the Agencies will continue to enforce under the current merger guidelines
- FTC’s successful (so far) challenge of St. Luke's acquisition of Saltzer is an example
- Continued payer-provider disputes will put more onus on the government to regulate the prices of both and to micromanage the contract provisions between them

Market Power – A Private Market Solution?

- Payers, providers, and employers should adopt voluntary protocols relating to quality measures and cost efficiency, including appropriate contract provisions
- Such voluntarily contracting protocols would include quality measures, benchmarks, and a savings allocation formula that includes giving some savings back to consumers
- Appropriate data would need to be collected and shared among payers, providers and consumers
- Models and results developed could be adapted for agency antitrust review purposes
- Both network model ACOs and merged entities (or those seeking to merge) could be evaluated according to these developing “value” criteria, incorporating clinical and financial integration