Accountable Care Organizations in the United States and England: Testing, Evaluating, and Learning What Works

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Outline

- Accountable Care Organizations – Definitions and eligibility criteria
- Numbers and types
- Early experience and lessons learned
- Future evolution and key questions
- Some important enablers
Accountable Care Organizations (ACOs)

Entities that accept accountability for the cost and quality of care provided to a defined population of potential patients
1. A willingness to become accountable for the quality, cost, and overall care of the Medicare FFS beneficiaries it treats;

2. Entrance into an agreement with the Secretary to participate in the program for not less than 3 years;

3. A formal legal structure that allows the organization to receive and distribute payments for shared savings;

4. The inclusion of primary care professionals that are sufficient for the number of Medicare FFS beneficiaries assigned to the ACO: “At a minimum, the ACO shall have at least 5,000 such beneficiaries assigned to it under subsection (c) in order to be eligible to participate in the ACO program”;
5. Provision to the Secretary of information regarding the professionals who participate in the ACO (so that the Secretary may decide whether they are sufficient to support the care of the patients assigned), the implementation of quality and other reporting requirements, and the determination of the allocation of shared savings;

6. A leadership and management structure that includes clinical and administrative systems

7. Defined processes that promote evidence-based medicine and patient engagement, reporting on quality and cost measures, and care coordination;

8. Demonstration that the organization meets patient-centeredness criteria.
Accountable Care Organizations

• 30 Pioneers
• 337 Shared Savings
• Over 200 Private Sector

• 606 Overall

Source: Leavitt Partners, LLC, 2014
ACOs Are Serving Millions Nationwide

• 5.3 million Medicare beneficiaries
• 6.1% of U.S. population—approximately 20 million
• 55% of the U.S. population has access to an ACO

By State

• Oregon: >25%
• Alaska, Iowa, Massachusetts, Maine, New Hampshire, Utah, Vermont: >10%
• California: 40+ ACOs

Source: Leavitt Partners, LLC, 2014
Estimated ACO Penetration by State

% ACO Lives

- >15%
- 10-15%
- 5-10%
- 3-5%
- 1-3%
- 0-1%
Most Recent 123 Shared Savings ACOs

- 13 already had contracts with private payers
- Average number of covered lives = 12,000

Source: Leavitt Partners, 2014
What are they doing?

Contracts

• 57% One contract only
• 79% Shared Savings contingent on meeting quality standards
• 56% of private contracts included some downside risk
• 56% of private payer contracts included upfront payments—for care management or capital investment

Source: National Survey of Accountable Care Organizations, Dartmouth-Berkeley, October 2012-May 2013
What are they doing? (cont’d)

Prescribing

• 77% of private contracts held the ACO responsible for prescription drug costs
• 73% use a formulary to control drug costs
• About half use e-prescribe and confirm fill

Other

• 28% included a community health center

Source: National Survey of Accountable Care Organizations, Dartmouth-Berkeley, October 2012-May 2013
Those with a Community Health Center (N=44)

• No more likely to receive an upfront payment
• But were more likely to find it very challenging to secure sufficient funds
• More likely to integrate behavioral health into primary care (28% vs. 8%)
• More likely to involve patients in their care (32% vs. 18%)

Source: National Survey of Accountable Care Organizations, Dartmouth-Berkeley, October 2012-May 2013
ACOs can improve care

ACOs can control costs
Schematic overview of the Accountable Care Organization (ACO) Evaluation Logic Model

Environmental context → Local readiness → Implementation activities → Intermediate outcomes → Impact

National and state context:
- Policies, investments, and activities

Local context:
- Market structure and health IT capacity

ACO structure and capabilities:
- Governance, leadership, and health IT infrastructure

ACO contract characteristics:
- Degree of risk, incentives for health IT adoption

Implementation of health IT, health information exchange across providers → Data sharing by providers and payers → Development of public reporting infrastructure → Degree of integration of care achieved

Degree of health IT capacity achieved → Improvement in care processes → Reduced costs

Improved access and experience

ACO formation and implementation activities

ACO performance

| Consumer concerns about access, stinting on care, and program focus | • Performance measures that reflect important goals and outcomes, speed of evolution and strength of linkage between quality improvement and bonuses.  
• Consumer role in governance; consumer notification approach; “patient-centeredness” criteria |
|------------------------------------------------|--------------------------------------------------|
| Will program lead to real savings for both public and private payers? | • Whether and how payment models make transition from shared savings to risk bearing (i.e., stronger incentives).  
• All payer models provide stronger incentives and mitigate risk of monopoly pricing; transparency on costs may also help |
| Limited financial, technical and data support for clinical transformation | • Ability of organizations to recover overall investment costs associated with implementing needed clinical reforms  
• Risk bearing (freeing up more resources to improve care than siloed, fee-for-service payments permit) and multi-payer models could increase financial resources to support improvement.  
• Availability of timely CMS data to support care improvement, and degree of alignment with other payment reforms in Medicare (meaningful use, quality reporting, readmissions, etc.) |
| Provider concerns about anti-trust and fraud provisions of current law | • Clarity of guidance on how collaborative models can be structured to avoid anti-trust concerns  
• Whether and how safe-harbor provisions from anti-fraud and anti-kickback provisions are designed and implemented. |
| High cost of implementation, especially for less integrated providers | • Degree to which requirements for participation, such as performance reporting, are front-loaded or phased in  
• Whether up-front financial support is provided or can be implemented simultaneously |
| Design issues: attribution, target setting, incentive structure | • Design of evaluation approach and degree to which this supports rapid learning and timely adaptation of design  
• Degree to which regulations are drafted to allow further refinement and modification of the program |

The Upside

Of the 32 Pioneer ACOs:

• **18** Generated savings for Medicare
• **13** Generated enough savings to keep $76.1 million
• **32** Successfully reported quality measures
• **25** Had lower risk-adjusted readmission rates (compared with benchmark rate for all Medicare fee-for-service beneficiaries)

The Downside

Of the 32 Pioneer ACOs:

• 14 Generated losses for Medicare
• 7 Increased costs enough that they owe Medicare $4.5 million
• 7 Will transition to Medicare’s more flexible Shared Savings Program
• 2 Will drop out of Medicare accountable care

Comparative Results – CMS Evaluation

• Small collective impact on slowing total Medicare spending growth ($50 per beneficiary less than it would have been) in the first year

• But most Pioneer ACOs saw growth similar to their local market comparisons

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

Results of Massachusetts Alternative Quality Contract (AQC)

- Based on global budget and pay-for-performance
- 2.8 percent savings over two years compared to control group
- Shifted procedures, imaging and tests to facilities with lower fees plus reduced utilization
- Quality of care improved by 3.7 percentage points on chronic care management measures
- Savings were greater in second year than first year, and quality improvement was greater in second year than first year.

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

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

Early Lessons from Brookings-Dartmouth ACO Pilot Studies

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

Key Findings and Lessons
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
Future Evolution in the United States
Three Key Questions

• Can the ACOs experiencing early success sustain their success over time?

• How rapidly will ACOs or similar organizations spread across the country?

• Can they develop quickly enough to make a sustainable difference in lowering cost growth while improving overall quality of care and population health – the Triple Aim?
Characteristics of Physician Practices Participating in ACOs – 2012-2013

- 280 Practices participating in ACOs
- 186 Planning to participate within 12 months
- 717 Not participating or planning to participate

Those participating are:

- Larger (100+)
- More likely to receive patients from an independent practice association (IPA)
- Score higher on patient-centered medical home index measuring ability to care for patients – particularly those with chronic illness
- Less likely to be owned by a hospital/health system

Source: School of Public Health, Division of Health Policy and Management, UC Berkeley, October 2013
### Patient-Centered Medical Home Processes Associated with ACO Participation

<table>
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<tr>
<th>PATIENT CENTERED MEDICAL HOME INDICES</th>
<th>Overall</th>
<th>ACO Participant</th>
<th>Planning to Participate in 12 mos.</th>
<th>Not part of an ACO &amp; not planning</th>
<th>p-value</th>
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<tr>
<td>n=(880)</td>
<td>n=(226)</td>
<td>n=(140)</td>
<td>n=(514)</td>
<td></td>
<td></td>
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<tr>
<td>Overall PCMH index for NSPO3 (0 - 100)*</td>
<td>39.24</td>
<td>53.09</td>
<td>42.21</td>
<td>31.93</td>
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<td>Chronic disease management index</td>
<td>33.53</td>
<td>56.98</td>
<td>33.28</td>
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<td>Quality and patient safety index</td>
<td>39.92</td>
<td>61.35</td>
<td>41.10</td>
<td>30.08</td>
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<td>Patient engagement index</td>
<td>31.49</td>
<td>41.47</td>
<td>34.86</td>
<td>25.68</td>
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<td>Prevention/health promotion index</td>
<td>29.89</td>
<td>43.54</td>
<td>37.03</td>
<td>20.86</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

**SOURCE:** National Study of Physician Organizations III (Jan 2012 – May 2013). **NOTES:** N=880. Results are weighted to be nationally representative. P-values were derived from F-tests. *Score is a percentage of total possible points out of 25.
Patient-Centered Medical Home Index Components

**Care Coordination/Integration**
- EMR
- Access to medical records
- Pharmacy electronic coordination
- Chronic disease registries
- Nurse care managers for chronic disease
- Collect information on race/ethnicity/language
- Hospital transitions
- Patient tracking

**Quality and Safety**
- Participate in quality improvement
- Rapid-cycle quality improvement
- Collect data from electronic records
- Performance feedback to physicians
- Clinical decision support
- Patient educators with dedicated time
- Patient reminders
- Incorporate feedback from physicians
- Tobacco cessation
- Patient receives office visit summary

**Additional Measures**
- Personal Provider
- Physician Directed Medical Practice
- Enhanced access (extended hours, group visits, e-mail)
Four Enablers of Integrative Care

• Aligned payment systems and incentives
  – Risk-based payments to providers
  -- Importance of “phase in” – co-evolution of new payment models and provider ability to respond to new incentives

• Manageable set of targeted quality and outcome measures
  -- Can promote collaboration

• Clinical and managerial leadership and infrastructure to develop effective alliances and networks

• Commissioners supporting integrated care through new performance-payment and contracting arrangements
Have you seen this billboard yet?

We work to keep you out of bed.

VISIONARY HEALTH SYSTEM
Thank You

“Healthier Lives In A Safer World”