

Accountable Care and Health Care Reform: What's Next?

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Overview

- **Health Care Reform: Policies and Politics**
- **Accountable Care and “Bending the Curve” of Cost Growth and Quality Improvement**
- **Alignment: ACOs and Other Health Care Reforms**
- **Next Steps for Health Care Providers**

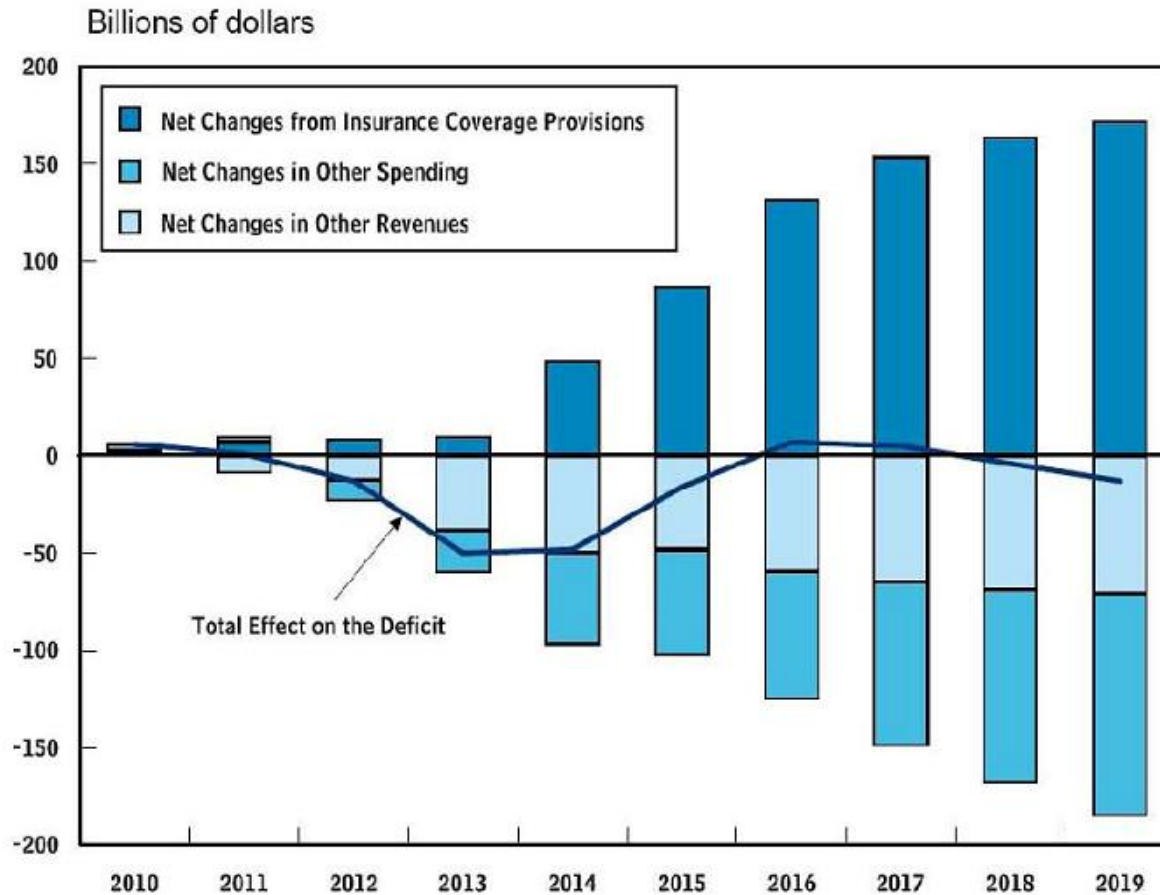
Health Care Reform Legislation: Coverage

- **Insurance Market Reform, with Guaranteed Issue/ Community Rating and Exchanges**
 - Some reforms starting now: pre-existing conditions for children, children up to 26, no lifetime limits
 - High-risk pools and high-cost retiree reinsurance
- **Individual Requirement for Coverage**
 - Mandate with penalty of 2.5% of income by 2016 (small relative to cost of insurance)
 - Essential benefits set by HHS, “comparable” to employer coverage
 - Penalties for employers not offering coverage
- **Income-Related Subsidies for Affordability**
 - Medicaid coverage to 133%+ of poverty (100% Federally funded to 2016, then 90%) – est. 14M new enrollees
 - Subsidies up to 400% of poverty

Health Care Reform Legislation: Financing

- **Medicare Payment Reform**
 - Payment Reductions to Offset Spending Increases: Medicare Advantage payment reductions (over \$200B), lower updates (1.1%+) for other providers
 - Independent Payment Advisory Board
 - Closing Donut Hole by 2020 through Pricing “Discounts,” Additional Subsidies
 - Provider Payment Reforms to Drive Changes in Health Care (mainly pilot programs)
- **Taxes, Other Revenues to Offset Remaining New Spending**
 - Industry Fees: Insurers, Pharma, Device Manufacturers
 - Excise Tax on High-Cost Employer Plans Starting 2018
 - Individual Payroll Tax Increase of 0.9% plus new 3.8% tax on non-wage income for individuals earning over \$200,000, not indexed
 - Additional revenues from outside health care (student loan reform, other taxes)
- **Overall Health Care Utilization and Spending, Federal Health Care Spending Projected to Rise (\$390B more through 2019)**

Deficit Consequences of Health Care Reform Legislation



Source: Goldman Sachs based on CBO estimates.

Note: Figures exclude the effect of education provisions in the Reconciliation Act of 2010 (Public Law 111-152).

Legislative and Judicial Outlook

- Gridlock on major issues, except Medicare physician payments
- Lots of Congressional oversight hearings
- Appropriations restrictions
- Piecewise repeal/revision?
 - IRS 1099 business relationship reporting
 - More significant changes (comparative effectiveness, Independent Payment Advisory Board) unlikely
- Judicial action
 - Current status
 - Key issues: Interstate commerce clause interpretation, severability
 - Appellate and Supreme Court outlook
- Potential for substantial revisions after 2012
 - Implications of White House and Congressional control
 - Mandate likely to be revisited regardless of election, Supreme Court
 - Subsidies and Taxes, Payment Updates
- Enduring features
 - Alternatives to individual mandate; pressures to reduce costs
 - Payment reform

Deficit Outlook

- **Large, Long-Term, Politically Meaningful Deficits**
 - \$1.4+ trillion each year 2009-11 (8% GDP), over \$5T over 5 years
 - Substantial long-term deficits: Over \$1T and rising 2020 (5% GDP and growing – at least 2% higher than “sustainable”)
 - Freezing or reducing all non-defense discretionary spending (\$1.4T 2011) doesn’t help much
 - Many states face difficult shortfall projections due to Medicaid
- **ACA Steps: Tighter Price Controls, Subsidy Limits After 2018**
 - Permanent reduction in Medicare payment updates (-1.1%)
 - Independent Payment A Medicare spending growth of GDP+1% in 2018, plus slower growth in per-capita insurance subsidies
 - Much of subsidy growth limited to CPI after 2018
- **Focus of Future Health Care Reform on Cost Reduction**

Deficit Reduction Proposals

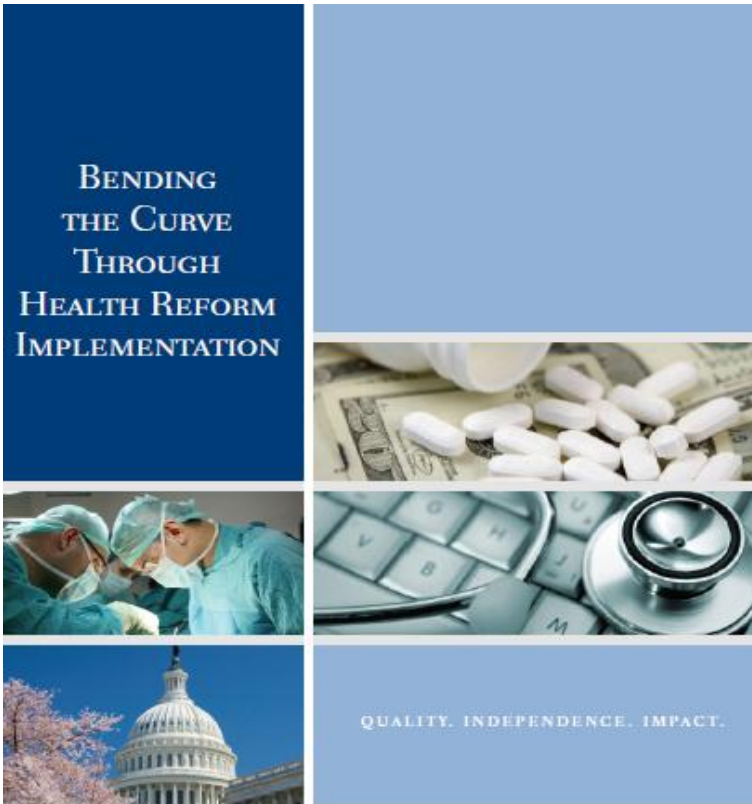
- **President's Bipartisan Fiscal Commission (Fall 2010)**
 - Stronger IPAB
 - More pressure on FFS/MA payments, rationalize traditional Medicare benefits
- **Ryan/House Republican Plan**
 - Repeal all ACA coverage provisions and IPAB
 - Redirect all other Medicare payment reductions (including MB reductions) to “strengthening Medicare”: fix physician payment/SGR and apply rest to deficit reduction
 - “Premium support” (subsidies increasing with CPI) in Medicare and Medicaid block grants increasing with CPI, to slow spending growth further
- **President's Framework**
 - IPAB reduces spending growth to CPI+0.5% per capita
 - “Value-based” benefit design
- **Back to the Future: Tighter Medicare/ Medicaid Price Regulation**
 - Main health care savings in BBA 1997 and ACA 2010
 - Achieves short-term Federal savings without reducing benefits
 - Not a strategy to improve value
- **Alternative: Payment Reform and Coverage Reform**

Bending the Curve

Full-text available at:
<http://www.brookings.edu/health>

Full-text version includes:

- Additional context
- Specific sub-recommendations
- Breakdown of legislative vs. regulatory actions



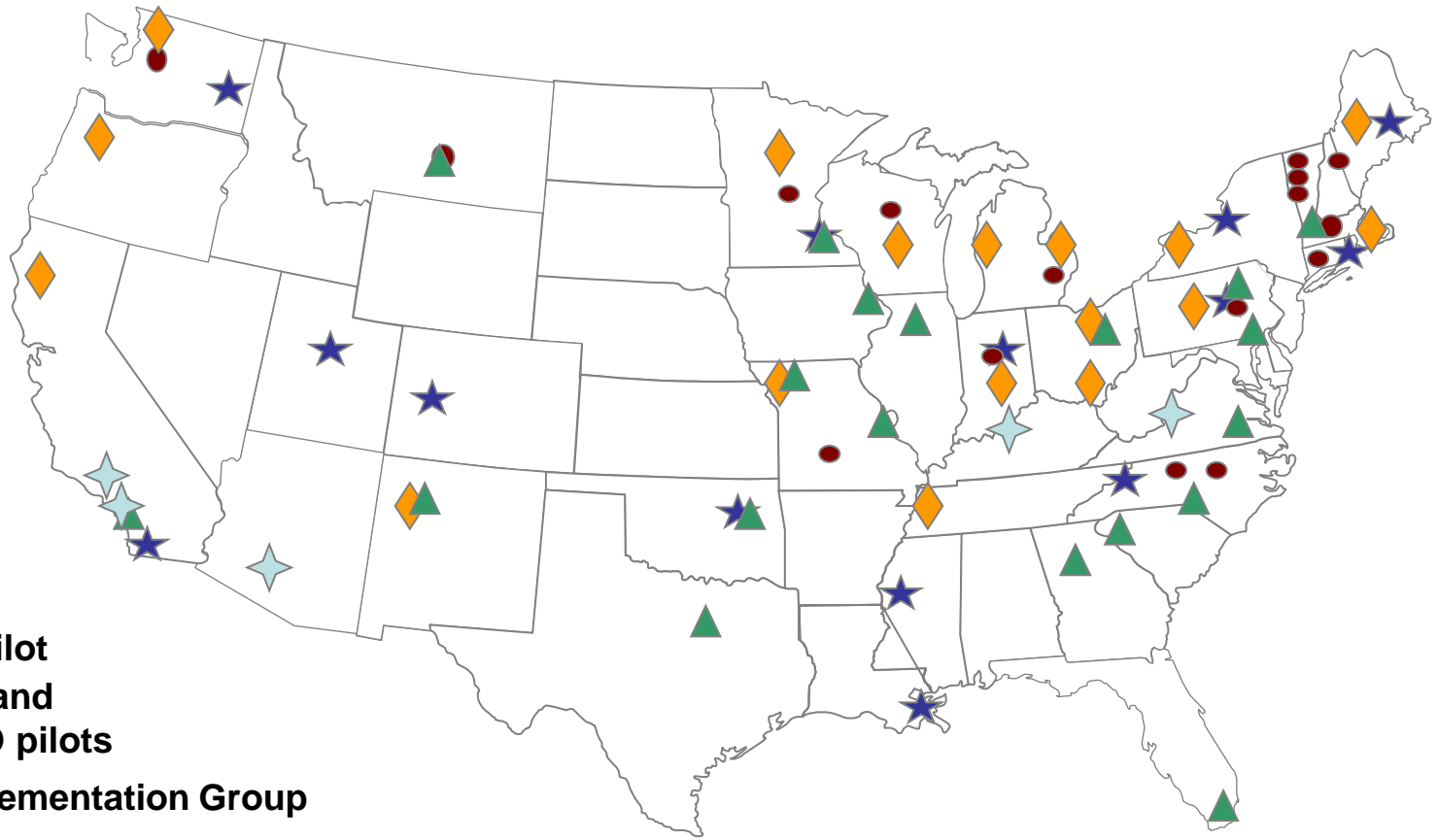
Achieving Real Health Care Reform

- ***Expanding insurance coverage and squeezing prices won't do it***
 - ***Employer leadership needed***
- Support what we want: Better quality, lower costs
- Requires alignment on accountability for better quality, lower costs – *system wide*
- Four key elements
 - Measurement and Evidence
 - Payment
 - Insurance Choice
 - Benefits

Reform Payments Based on Value: Core of Health Care Legislation

- **Measurement of Quality and Cost Provides Foundation for Payments Based on Value: Accountable Care**
- **“Shared Savings”**
- **Examples of Accountable Care**
 - Medicare Physician Group Practice Demonstration
 - Medicare Regional Demonstrations: Sustaining Health Insurance Exchanges
 - Community Care of North Carolina
 - Indiana Regional Health Insurance Exchange
 - Brookings-Dartmouth Accountable Care Organization (ACO) pilots
 - Premier ACO Network
 - Private Health Insurer ACOs
 - Upcoming Medicare and Medicaid ACOs

“Shared Savings” Payment Reform Pilots being Implemented Across the Country



- ★ Brookings-Dartmouth Pilot
- PGP, MHCQ and regional ACO pilots
- ▲ Premier Implementation Group
- ★ ONC Beacon Site
- ◆ AF4Q Pilot Sites

Next Step Toward Medicare ACOs: Medicare Shared Savings Proposed Rule

- **Qualification requirements**
- **Shared savings benchmarks**
- **Performance measurement**
- **Other issues**
- **Lots more Information**
 - **CMS summary:**
cms.gov/sharedsavingsprogram
 - **Commonwealth Fund summary:**
commonwealthfund.org/Content/Publications/Other/2011/Proposed-Rules-for-ACOs.aspx
 - **Kaiser Health News summary:**
kaiserhealthnews.org/Stories/2011/March/31/ACO-Documents-In-The-News.aspx
 - **Brookings-Dartmouth ACO Learning Network:** acolearningnetwork.org

1. ACO Qualification Requirements

- Sufficient quality improvement/clinical integration program (evidenced-based guidelines, patient-centeredness, quality assurance and support, etc.) with special emphasis on complex and vulnerable patients
- How savings will be shared among participating providers
- Leadership and management structure (clinical and administrative systems), including full-time board-certified physician as medical director and governing body with ACO provider and consumer representation
- Beneficiary education, access, and communication, including: notification by providers; “opt out” of beneficiary Medicare data being shared with ACO; and clearance of marketing materials
- Partnership with community stakeholders
- Compliance plan
- Flexibility in how to demonstrate most requirements – previous experience will help

2. ACO Payment Methods: Benchmark Calculation

- **Identify beneficiaries assigned to ACO retrospectively (but ongoing data/ measure feeds to provide insights about likely beneficiaries)**
- **Use three previous “baseline” years of total Medicare A+B spending to calculate base-year per-capita spending benchmark**
 - **Some risk adjustment in baseline amount**
- **Over 3-year ACO contract, benchmark updated annually based on actual increase in national average per capita A+B spending amount**
- **Track 1: two years of “one-sided” risk – share up to 50% savings above 2% threshold; then two-sided risk**
- **Track 2: “two-sided” risk from start – share up to 60% of savings and higher costs, if beyond 2% minimum**
- **Savings and losses are capped**

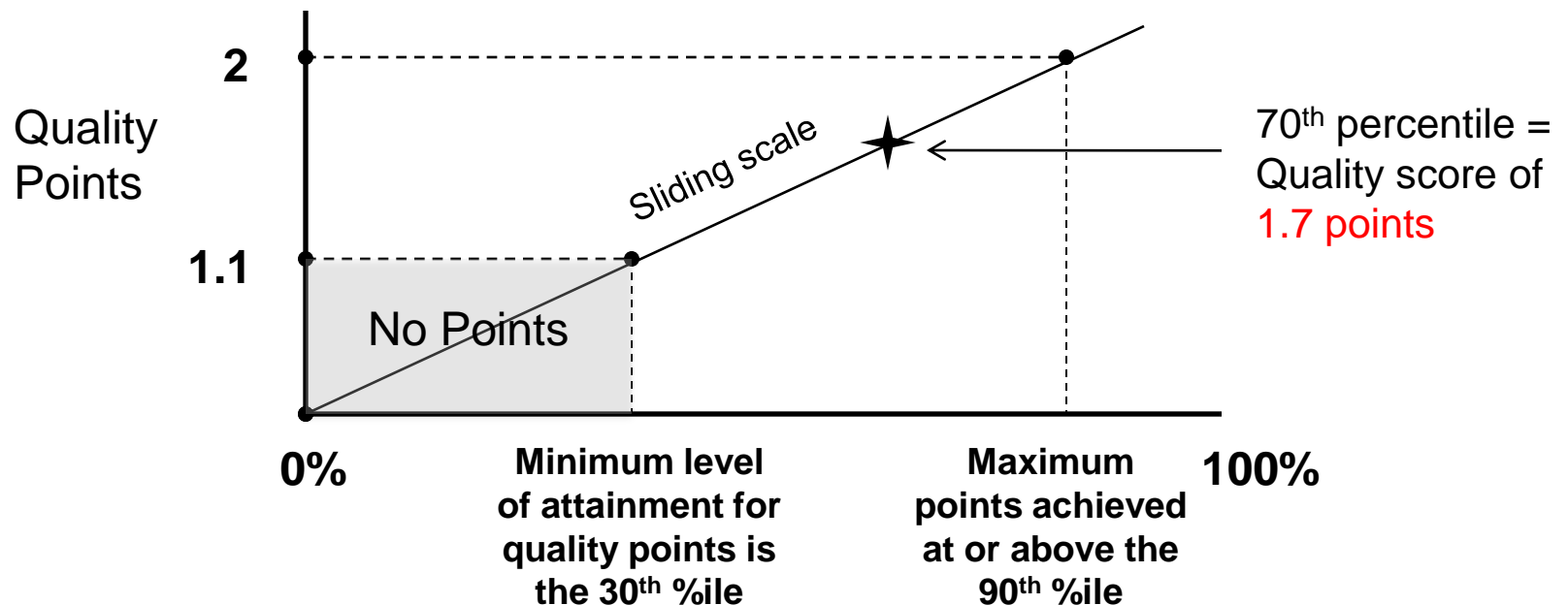
3. Performance Measures – ACO Gets More of Shared Savings with Higher Quality Performance

Domain (# of Measures)	Sample Measures	Data Source(s)
Patient Safety (2)	<ul style="list-style-type: none"> Health Care Acquired Conditions Composite 	7 measures are survey-based (CG-CAHPS) 11 measures can be calculated using Medicare claims (Part A & B) only 5 measures derive from ACO attestation (part of MU incentive program) 42 measures require clinical data, which may come from labs, registries, patient records, and other clinical data sources (measures are part of PQRS)
Patient/Caregiver Experience (7)	<ul style="list-style-type: none"> Getting Timely Care, Appointments, and Information Health Status/Functional Status 	
Preventive Health (9)	<ul style="list-style-type: none"> Influenza Immunization Colorectal Cancer Screening 	
Care Coordination (16)	<ul style="list-style-type: none"> Risk-Standardized, All Condition Readmission Medication Reconciliation Care Transition Measure % All Physicians Meeting Stage 1 HITECH Meaningful Use Requirements 	
At-Risk Population/Frail Elderly (31)	<ul style="list-style-type: none"> Diabetes Mellitus: HbA1c Control (<8%) Heart Failure: Weight Measurement CAD: Drug Therapy for Lowering LDL-C COPD: Spirometry Evaluation Falls: Screening for Fall Risk 	
Total:	65 measures across 5 domains	

Note: Over time CMS seeks to add more measures and align proposed measures with those in use for CHIP, Medicaid, Special Needs Plans, etc.

Quality Measure Scoring

- In year 1, scoring is based on measure reporting only
- Beginning in year 2, quality performance is based on measure scores. For each measure, quality points are awarded on a sliding scale: no points below the 30th and maximum points (2) above the 90th percentile.
- Initially benchmarks calculated when available through FFS/MA, in later years benchmarks calculated from actually observed ACO performance.

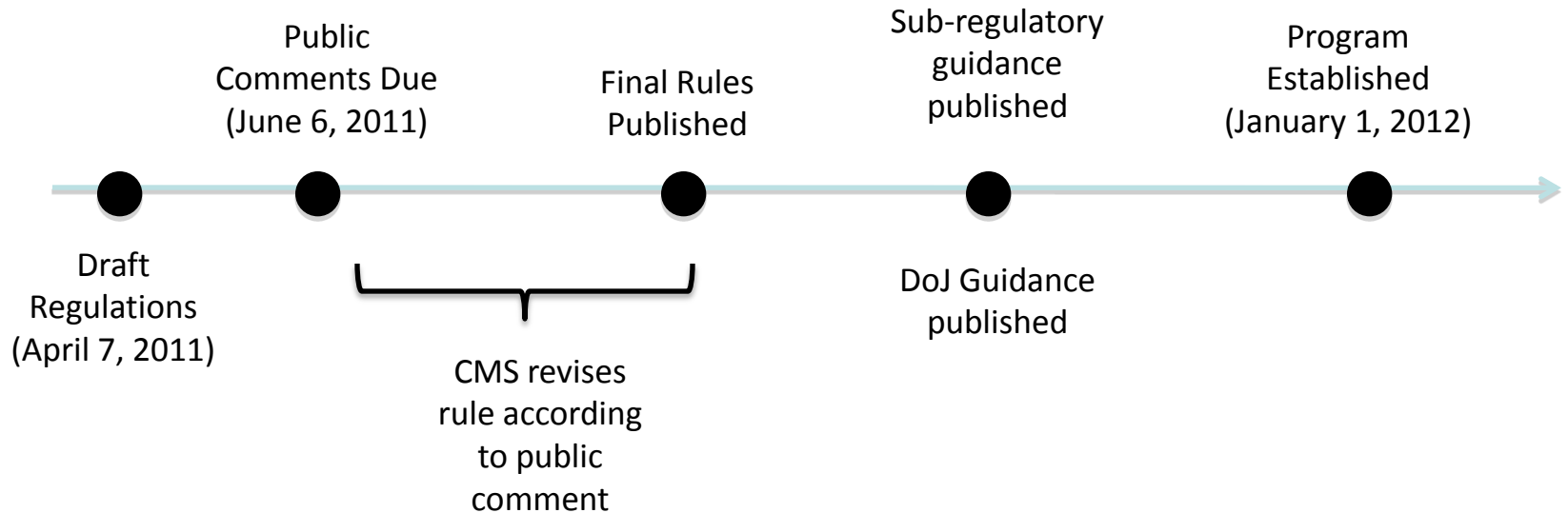


4. Other Issues in ACO Proposed Regulation

- Quarterly aggregate data reports based on most recent 12 months of data, and beneficiary-identifiable data for beneficiaries who do not “opt out”
- Guidance (and promise of 90-day review) from DOJ and FTC on antitrust issues, and guidance from OIG on Stark/antikickback/CMP issues
- Special provisions for ACOs with rural and low-income populations

¹ Initial aggregate reports will be based on the historical benes. used to calculate the benchmark; following reports based on most recent 12 months of data

Timeline for Medicare Shared Savings Program



Potential Synergy in Payment Reforms

Confusing aims

Nonexistent or poor measurement

Wrong financial incentives

Fragmented care



ACOs

ACOs can operate in conjunction with current payment structures

- FFS
- Bundled payments
- Partial/full capitation

ACOs can strengthen ongoing reform efforts

- Medical home
- Episode, readmission initiatives
- HIT
- Others

Synergy in Payment Reform

- Aligned Performance Measures
 - Quality (Including Impact on Outcomes, Population Health)
 - Cost/Efficiency Impacts
- Aligned Reform Priorities and Support
 - Chronic disease management, care coordination, major specialty care
 - Timely data for patient care
 - Supportive health plan and regional systems
- Aligned Payment Reforms
 - HIT Meaningful Use
 - Payments for Reporting/Performance
 - Medical Homes
 - Episode Payments
 - Accountable Care
 - Others
- Sufficient Scale
 - Sufficient capital to provide time, effort, and technical support for real delivery change (payers, providers- including physicians, equity)
 - Strategy for using and augmenting Federal payments
 - Systemwide leadership: regional collaborations; business groups; states; Federal government?

Key Issues for Health Care Organizations: Strategy Development

- **Critical Time for Developing Strategy of Reforms Aligning on Care Improvement, Prevention, Cost Reduction**
 - Many promising reform efforts underway – exact future policy directions unclear, but alternatives to reforming care will be worse
 - Tie together all reform initiatives through focus on quantifiable and synergistic impacts
 - Implementation with individual private payers
 - Implementation with state or regional collaborations
 - Medicare participation emerging – foundation and track record likely helpful
 - Technical support available – including Brookings-Dartmouth ACO Learning Network
- **Specific Steps for Clinical Care Improvements for Quality Improvement and Cost Reduction**
 - Care coordination
 - Preventive and primary care strategies, including preventing hospitalizations
 - Specialist care strategies
 - Supportive/palliative care strategies

Key Issues for Health Care Organizations: Leading Clinical Improvement

- **Performance Measurement to Support Better Care**
 - Range of patient-centered/ population measures, linked to actionable measures for providers
 - More work especially in patient experience, outcome, care coordination measures
- **Driving Synergies with Other Reform Initiatives for Financial, Organizational Support**
 - Key HHS/CMS Initiatives: HHS Safety Initiative (HAC measures, preventable readmissions)
 - Other payment reforms: Hospital Quality Reporting (moving toward more patient-focused measures); Value-Based Payment Initiative (likely to include many common elective surgical conditions); upcoming Physician Payment Reforms (moving toward episode and patient-level quality improvement)
- **Better Evidence on Cost and Outcome Impact of Quality Improvement Initiatives**
 - Learning networks, PCORI priorities
- **Successful Examples of Simultaneous Care/Payment Reforms**
- **Overall Business Strategy Must Include Increasing Focus on Accountability**