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

Mark McClellan, MD, PhD
Director, Engelberg Center for Health Care Reform
Senior Fellow, Economic Studies
Leonard D. Schaeffer Chair in Health Policy Studies
Brookings Institution
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).

Source: Congressional Budget Office Presentation to the Institute of Medicine, May 26, 2010
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

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<thead>
<tr>
<th>Domain (# of Measures)</th>
<th>Sample Measures</th>
<th>Data Source(s)</th>
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<tbody>
<tr>
<td>Patient Safety (2)</td>
<td>• Health Care Acquired Conditions Composite</td>
<td>7 measures are survey-based (CG-CAHPS)</td>
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| Patient/Caregiver Experience (7) | • Getting Timely Care, Appointments, and Information  
• Health Status/Functional Status | 11 measures can be calculated using Medicare claims (Part A & B) only |
| Preventive Health (9) | • Influenza Immunization  
• Colorectal Cancer Screening | 5 measures derive from ACO attestation (part of MU incentive program) |
| Care Coordination (16) | • Risk-Standardized, All Condition Readmission  
• Medication Reconciliation  
• Care Transition Measure  
• % All Physicians Meeting Stage 1 HITECH Meaningful Use Requirements | 42 measures require clinical data, which may come from labs, registries, patient records, and other clinical data sources (measures are part of PQRS) |
| At-Risk Population/Frail Elderly (31) | • 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.

![Quality Measure Scoring Diagram]

- 70th percentile = Quality score of 1.7 points
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

- Draft Regulations (April 7, 2011)
- Public Comments Due (June 6, 2011)
- Final Rules Published
- Sub-regulatory guidance published
- DoJ Guidance published
- Program Established (January 1, 2012)

CMS revises rule according to public comment
Potential Synergy in Payment Reforms

ACOs can strengthen ongoing reform efforts
- Medical home
- Episode, readmission initiatives
- HIT
- Others

ACOs can operate in conjunction with current payment structures
- FFS
- Bundled payments
- Partial/full capitation

Confusing aims
Nonexistent or poor measurement
Wrong financial incentives
Fragmented care
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**