

Accountable Care Organizations (ACOs) – Why now?

Rob Parke,
Consulting Actuary
Milliman, Inc., New York, NY
rob.parke@milliman.com
(646) 473-3206

October 25, 2011

Agenda

- Health care reform overview
- The cost problem
- Payment Reform
 - National
 - Massachusetts
- High level observations

Health Care Reform - simplified

- **Coverage Expansion** to an estimated 32 million Americans
 - Medicaid Program 16 million
 - Government Subsidies through State Based Exchanges 16 million
 - Individual and Employer mandates
- **Insurance Market Reforms** to broaden coverage and stabilize private coverage
 - Exchanges
- **Financing** (taxes, slower Medicare spending and fees) to pay for expansion

Susan Dentzer – Editor in Chief Health Affairs Magazine

Health Care Reform – simplified (cont.)

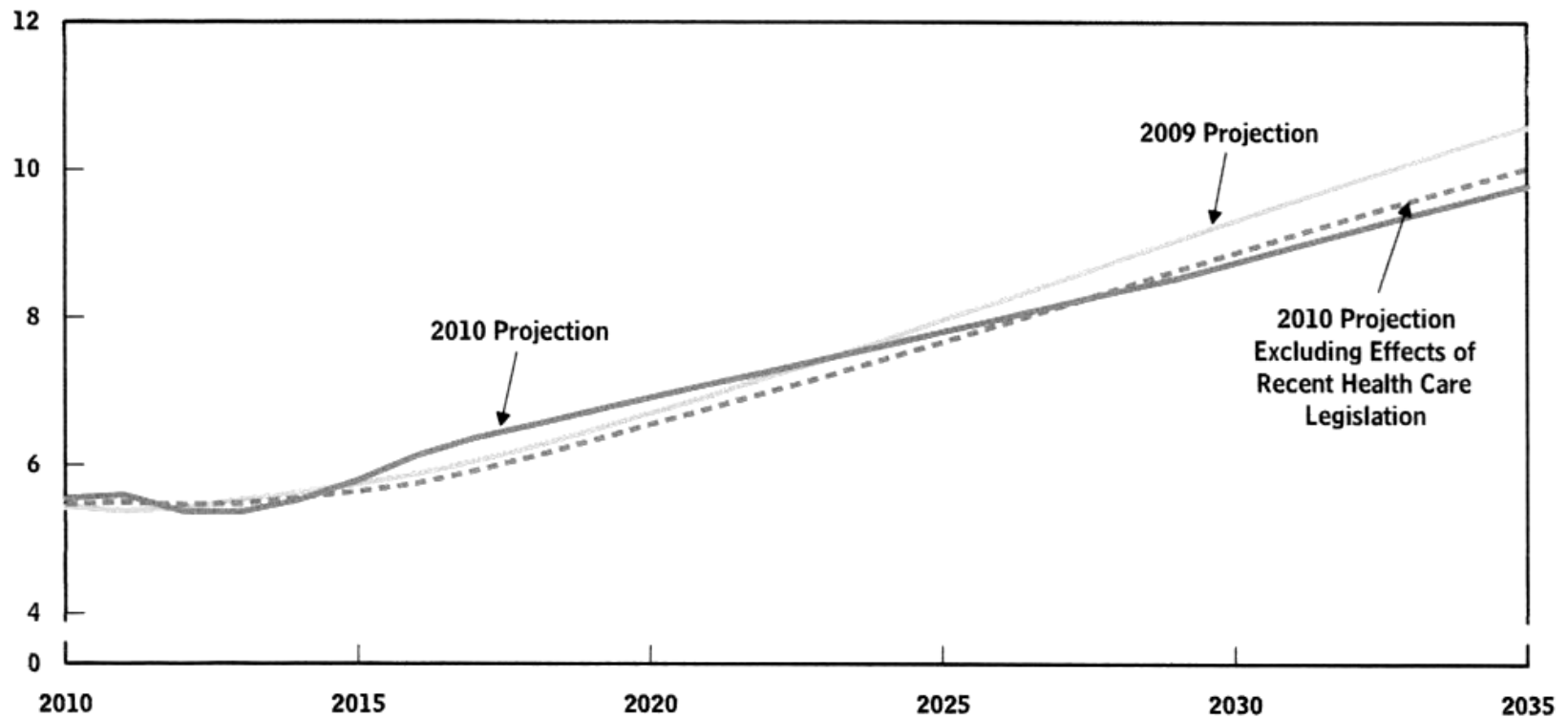
- **Delivery Payment Reform** and experiments to slow growth rate of health care spending
 - Independent Payment Advisory Board
 - Comparative Effectiveness Research
 - Accountable Care Organizations
- **Health Promotion and Prevention Initiatives** - \$15 billion prevention fund
- **Other** – workforce provisions, CLASS ACT, follow-on biologics, etc.

Susan Dentzer – Editor in Chief Health Affairs Magazine

Healthcare Spending

Comparison of CBO's 2009 and 2010 Projections of Mandatory Federal Spending on Health Care Under the Extended-Baseline Scenario

(Percentage of gross domestic product)



Source: Congressional Budget Office.

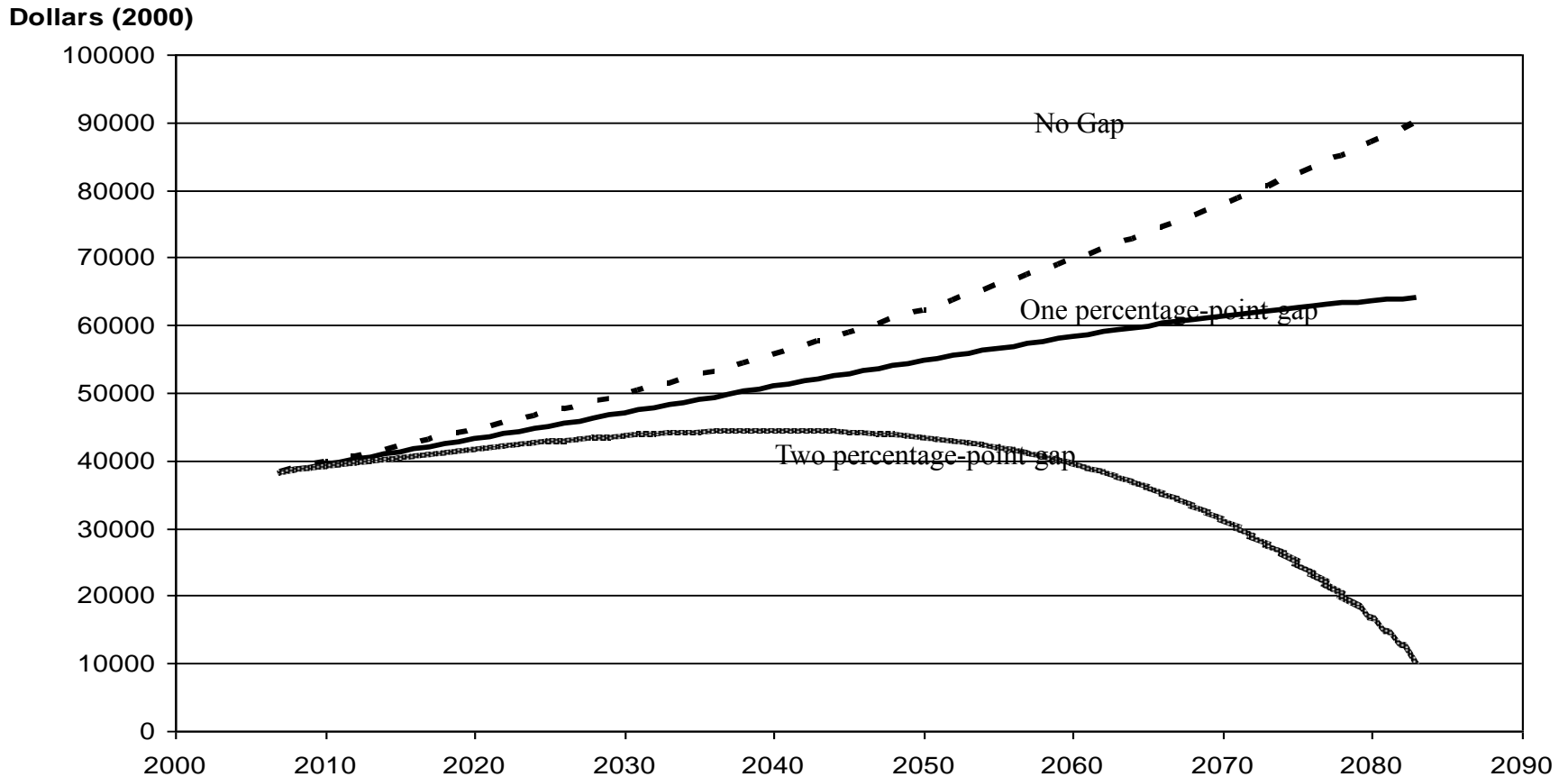
Source: Congressional Budget Office, The Long-Term Budget Outlook, June 2010
<http://www.cbo.gov/ftpdocs/115xx/doc11579/06-30-LTBO.pdf>

Gap between CPI and Medical Expenses

- 1% point gap: health care is “affordable” through 2083; 54% of real increase in per capita income goes to health care
- 2% point gap: health care affordable only through 2020; over 75 years, 118.5% of real increase in per capita income devoted to health care (i.e., implausible)

Michael E. Chernew, Richard A. Hirth, and David M. Cutler
Increased Spending On Health Care: Long-Term Implications for The Nation
Health Affairs, September/October 2009, vol. 28, Number 5, pp. 1253-1255.

Gap between CPI and Medical Expenses

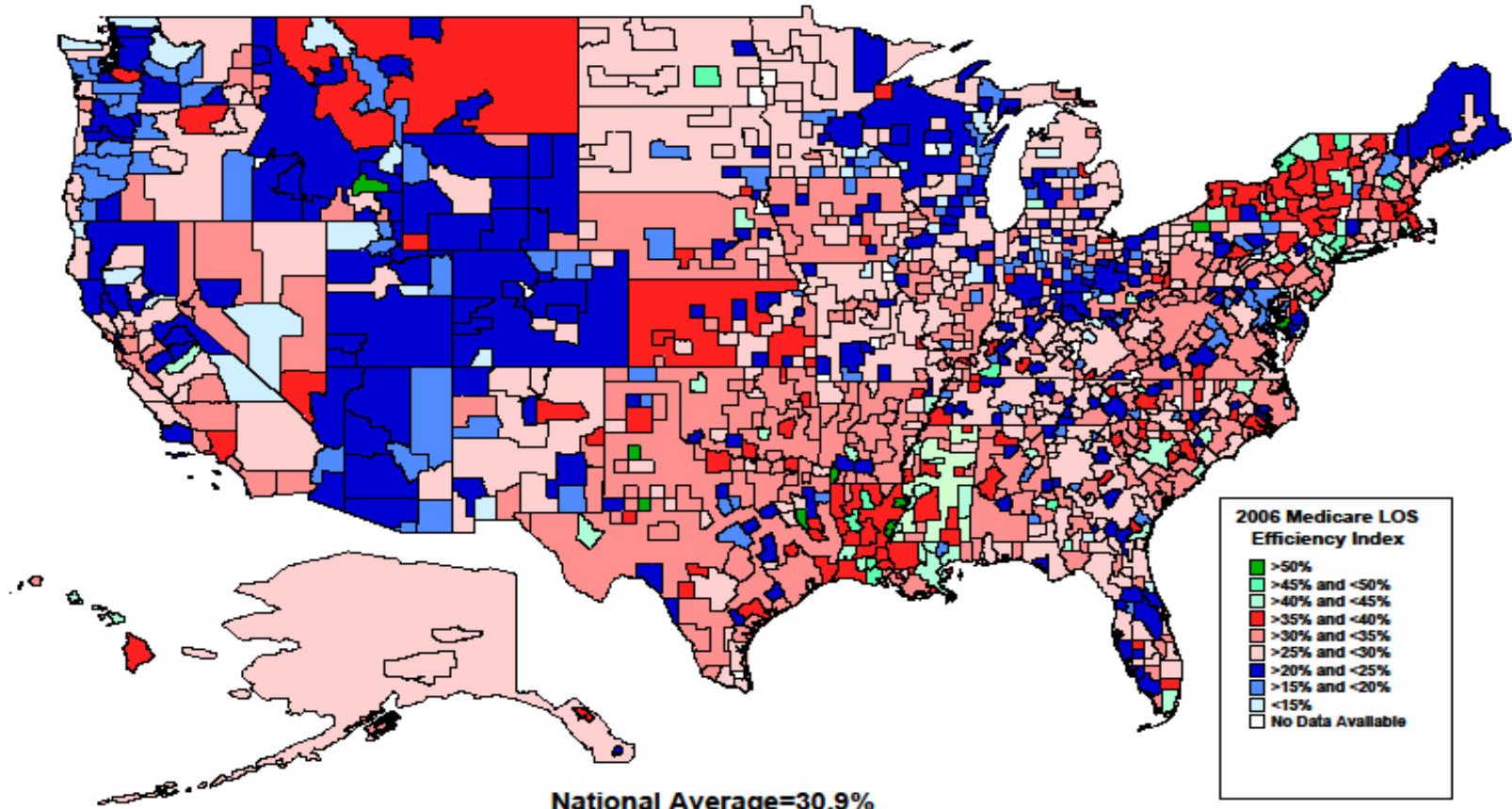


Waste

A 2005 National Academy of Engineering and Institute of Medicine report found that “an estimated thirty to forty cents of every dollar spent on health care, or more than a half-trillion dollars per year, is spent on costs associated with overuse, underuse, misuse, duplication, system failures...and inefficiency .”

“Reid, P P., Compton W D., et al. Building a Better Delivery System: A New Engineering/Health Care Partnership. Washington, D.C.: *The National Academies Press*; 2005, page 1

Medicare Hospital Efficiency Index 2006 Days Avoidable Due to LOS Above Benchmark



Source: Hospital Efficiency Index

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Average Number of Physician Visits

Medicare Enrollees last 6 months of life (2000 – 2003)

<i>U.S. News and World Report Honor Roll Academic Medical Centers</i>	
UCLA Medical Center	52.1
New York-Presbyterian Hospital	42.5
Massachusetts General Hospital	42.0
Cleveland Clinic	32.1
UCSF Medical Center	30.4
Johns Hopkins Hospital	29.8
Barnes Jewish Hospital	29.5
Mayo Clinic (St. Mary's Hospital)	23.8
Duke University Hospital	23.3
University of Washington Med. Center	22.6

New York University Hospital = 76.2

Inpatient and Part B Medicare Spending

Medicare Enrollees last 6 months of life (2000 – 2003)

<i>U.S. News and World Report Honor Roll Academic Medical Centers</i>	
UCLA Medical Center	\$72,793
New York-Presbyterian Hospital	\$69,962
Massachusetts General Hospital	\$60,653
Cleveland Clinic	\$56,859
UCSF Medical Center	\$50,716
Johns Hopkins Hospital	\$47,880
Barnes Jewish Hospital	\$44,463
Mayo Clinic (St. Mary's Hospital)	\$37,765
Duke University Hospital	\$37,271
University of Washington Med. Center	\$35,465

Hahnemann University Hospital = > \$100,000

Physician Requirements

2006

Benchmark	National Required Physician FTEs Surplus/(Shortage)
Manhattan, New York	(27,274)
Rochester, Minnesota	30,163
Lebanon, New Hampshire	34,298

Physician Requirements

2020 – 56% increase in Americans >65 and current training rates

Benchmark	National Required Physician FTEs Surplus / (Shortage)
Manhattan, New York	(44,762)
Rochester, Minnesota	49,917
Lebanon, New Hampshire	56,692

The Cost Conundrum

What a Texas town can teach us about health care.

by Atul Gawande

June 2009
www.newyorker.com/



The Hot Spotters

Can we lower medical costs by giving the neediest patients better care?

by Atul Gawande

January 24, 2011
www.newyorker.com/



Fee-for-Service

“The only truly promising way to save money is to change the way health care is organized and delivered. In the United States, 85% of doctors work in small, fee-for-service practices. Many of these doctors are very good and hard-working. But they are autonomous, not members of teams. They do not systematically share information with one another. They are unable and unwilling to be held accountable for the quality and cost of the care they deliver.

The employment based health insurance system has created this situation by not encouraging people to consider value for their money when they choose doctors.”

“Health Care with a Few Bucks left Over” Alain Enthoven New York Times
December 28, 2008

Fee-for-Service

“Some American medical practices do emphasize economy. They are very large, multispecialty group practices in which doctors work together to improve quality and keep costs low. Their doctors share values and cultures of teamwork. They keep comprehensive electronic medical records, they share information, and they emphasize disease prevention and chronic disease management as a matter of course.

These doctors are usually paid salaries, not fees for services.....”

“Health Care with a Few Bucks left Over” Alain Enthoven New York Times
December 28, 2008

Incentives

“That any sane nation, having observed that you could provide for the supply of bread by giving bakers a pecuniary interest in baking for you, should go on to give a surgeon a pecuniary interest in cutting off your leg, is enough to make one despair of political humanity. But that is precisely what we have done. And the more appalling the mutilation, the more the mutilator is paid. He who corrects the ingrowing toe-nail receives a few cents: he who cuts your inside out receives hundreds of dollars, except when he does it to a poor person for practice. ”

Incentives

“Again I hear the voices indignantly muttering old phrases about the high character of a noble profession and the honor and conscience of its members As to the humor and conscience of doctors, they have as much as any other class of men, no more and no less. And what other men dare pretend to be impartial where they have a strong pecuniary interest on one side? Nobody supposes that doctors are less virtuous than judges; but a judge whose salary and reputation depended on whether the verdict was for plaintiff or defendant, prosecutor or prisoner, would be as little trusted as a general in the pay of the enemy.”

Incentives

“That any sane nation, having observed that you could provide for the supply of bread by giving bakers a pecuniary interest in baking for you, should go on to give a surgeon a pecuniary interest in cutting off your leg, is enough to make one despair of political humanity. But that is precisely what we have done. And the more appalling the mutilation, the more the mutilator is paid. He who corrects the ingrowing toe-nail receives a few **shillings**; he who cuts your inside out receives hundreds of **guineas**, except when he does it to a poor person for practice. ”

“The Doctor’s Dilemma” George Bernard Shaw 1906

What is an Accountable Care Organization (ACO)?

- Manage, coordinate and accept responsibility for quality and cost of care
 - **Groups** of health care providers
 - **Accountable** to payers for quality and cost of care provided to populations NOT patients
 - **Population** based reimbursement (payment reform)

What is an ACO?

- Medicare “Shared Savings” Program
- Medicare Pioneer Program
- “ACOs” in the private sector

Financial Risk changes incentives and roles

Fee For Service	Capitation
Risk: Payer	Risk: Provider
Hospital and Specialists: Revenue Center	Hospital and Specialists: Cost Center
Piece Work	Fixed Income
Provider Incentive: Maximize utilization	Provider Incentive: Manage utilization
Individual	Team

Financial Risk changes incentives and roles

Fee for Service	Capitation
Payer Concern: Over Utilization	Payer Concern: Under Utilization
Small Provider Groups	Large Integrated Groups
Primary Care Physicians: Less Influence Less Relative Income	Primary Care Physicians: More Influence More Relative Income

Utilization Efficiencies

**NATIONWIDE AVERAGE ASSUMPTIONS
COMMERCIAL LOOSELY MANAGED
July 1, 2009**

	Annual		Annual
	Admissions	Length of	Utilization
	per 1,000	Stay	per 1,000
	_____	_____	_____
Inpatient Facility -- Non-Maternity			
Medical	20.4 admits	3.85	78.6 days
Medical - Other Newborn	3.7 admits	6.78	25.1 days
Surgical	20.6 admits	4.26	87.7 days
Psychiatric	3.3 admits	8.18	27.0 days
Alcohol & Drug Abuse	2.1 admits	8.10	17.0 days
	_____	_____	_____
Subtotal	50.1 admits	4.70	235.4 days
Inpatient Facility -- Maternity			
Mother - Normal Deliveries	9.2 admits	2.09	19.2 days
Mother - Cesarean Deliveries	4.0 admits	4.03	16.1 days
	_____	_____	_____
Mother - Total	13.2 admits	2.67	35.3 days
Well Newborn	9.8 admits	2.03	19.9 days
Non-Deliveries	1.2 admits	3.00	3.6 days
	_____	_____	_____
Subtotal	14.4 admits	2.70	38.9 days
Skilled Nursing Facility	0.7 admits	21.14	14.8 days
	_____	_____	_____
Inpatient Facility -- Total	65.2 admits	4.43	289.1 days

Utilization Efficiencies

NATIONWIDE AVERAGE ASSUMPTIONS COMMERCIAL WELL MANAGED July 1, 2009			
	Annual		Annual
	Admissions per 1,000	Length of Stay	Utilization per 1,000
Inpatient Facility -- Non-Maternity			
Medical	14.2 admits	2.90	41.2 days
Medical - Other Newborn	2.4 admits	5.13	12.3 days
Surgical	12.3 admits	3.37	41.5 days
Psychiatric	1.2 admits	5.42	6.5 days
Alcohol & Drug Abuse	1.1 admits	3.09	3.4 days
Subtotal	31.2 admits	3.36	104.9 days
Inpatient Facility -- Maternity			
Mother - Normal Deliveries	11.2 admits	1.29	14.5 days
Mother - Cesarean Deliveries	2.0 admits	2.45	4.9 days
Mother - Total	13.2 admits	1.47	19.4 days
Well Newborn Non-Deliveries	11.1 admits 0.8 admits	1.26 2.00	14.0 days 1.6 days
Subtotal	14.0 admits	1.50	21.0 days
Skilled Nursing Facility	1.4 admits	12.00	16.8 days
Inpatient Facility -- Total	46.6 admits	3.06	142.7 days

Utilization Efficiencies

NATIONWIDE AVERAGE ASSUMPTIONS MEDICARE LOOSELY MANAGED July 1, 2009			
	Annual		Annual
	Admissions per 1,000	Length of Stay	Utilization per 1,000
Inpatient Facility -- Non-Maternity			
Medical	225.4 admits	5.26	1,185.6 days
Surgical	104.6 admits	5.70	596.2 days
Psychiatric	4.8 admits	10.48	50.3 days
Alcohol & Drug Abuse	0.8 admits	5.46	4.4 days
Subtotal	335.6 admits	5.47	1,836.5 days
Skilled Nursing Facility			1,778.6 days
Inpatient Facility -- Total	65.2 admits	4.43	3,615.1 days

Utilization Efficiencies

NATIONWIDE AVERAGE ASSUMPTIONS MEDICARE WELL MANAGED July 1, 2009			
	Annual		Annual
	Admissions per 1,000	Length of Stay	Utilization per 1,000
Inpatient Facility -- Non-Maternity			
Medical	133.0 admits	3.98	529.3 days
Surgical	67.3 admits	4.41	296.8 days
Psychiatric	2.1 admits	5.49	11.5 days
Alcohol & Drug Abuse	0.3 admits	3.19	1.0 days
Subtotal	202.7 admits	4.14	838.6 days
Skilled Nursing Facility			872.4 days
Inpatient Facility -- Total	65.2 admits	4.43	1,711.0 days

Healthcare Reform – Massachusetts

- Insurance Reform
 - Health Exchange
 - Individual and employer mandate
 - Restricted underwriting
 - Merged small and individual markets

“Predictably, the plan did little to slow the growth of health costs that already were among the highest in the nation”

“Massachusetts tries to reign in its health costs” – New York Times October 17, 2011.

Healthcare Reform – Massachusetts

- Cost - Delivery System/Payment Reform
 - Office of Attorney General Martha Coakley “Examination of Health Care Cost Trends and Cost Drivers”
 - Differences in payment to hospitals cannot be explained by variations in quality or mix of patients
 - Special Commission on Health Care Payment System
 - “Fee for Service payment rewards service rather than outcomes and efficiency”
 - Global Payments
 - ACOs
 - Patient Centered Medical Homes

Payment Reform Legislation - MA

Governor Duval Patrick

“We have shown the nation how to extend care to everybody and we’ll be the place to crack the code on costs.”

“Massachusetts tries to reign in its health costs” – New York Times October 17, 2011.

Payment Reform Legislation - MA

“Aims to expand the use of alternative payment methods and significantly reduce fee-for-service payments by the end of 2015”

www.masgov.com

MA Special Commission for Payment Reform

“To promote safe, timely, efficient, effective, equitable, patient-centered care, and thereby reduce growth and levels of per capita health care spending, the Special Commission recommends that global payments with adjustments to reward provision of accessible and high quality care become the predominant form of payment to providers in Massachusetts”

www.masgov.com

Key Features of Global Payment - MA

- The development of Accountable Care Organizations
- Patient-centered care and strong focus on primary care
- Patient choice
- Use of pay-for-performance (P4P) incentives
- Participation by both private and public payers
- Sharing of financial risk between ACOs and carriers
- Strong and consistent risk adjustment
- Cost and quality transparency
- Widespread adoption of the medical home model

Payment Reform Legislation - MA

“The Commissioner may disapprove rates that contain provider increases inconsistent with the following criteria:

- The rate of increase in the state’s Gross Domestic Product;
- The rate of increase in total medical expenses in the region as reported by the Division of Health Care Finance and Policy;
- A provider’s rate of reimbursement with a carrier, especially in relation to the carrier’s statewide average relative price;
- Whether the carrier and a contracting provider are transitioning from a fee-for-service contract to an alternative payment contract;
- As provider rates decline, carriers are required to factor such savings into the premiums charged to consumers.”

Conclusions

- National consensus developing that fee for service will no longer be predominant form of provider reimbursement
- Population budgets limited to CPI (CPI +1%?)
- The current model of continually increasing volume is increasingly unsustainable
 - Transition will be difficult
- Pressure for further provider integration
- There will be winners and losers

Questions