The Organization and Performance of Accountable Care Organizations: Early Evidence

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Objectives

- Promote effective organization and management of Accountable Care Organizations (ACOs)
- Inform policy options, especially for the Center for Medicare and Medicaid Services (CMS)
Outline

- Background: Accountable Care Organizations (ACOs) and health care reform
- Current study: inductive, mixed-methods
- Preliminary results: Four Key Themes
- Discussion
  - Implications for policy and managers
Focusing Attention on Improving Health Care Delivery

- Focus has been on how to pay for care for the uninsured
- Attention is shifting to improving the delivery of health care (cost, quality)
- This study focuses on one potentially important organizational form for change: Accountable Care Organizations (ACOs)
  - Several hundred in place, many more forming
- Specifically, Medicare’s Shared Savings ACOs
Definition of Accountable Care Organization

The ACA definition

- Organization of health care providers that agrees to be accountable for quality, cost and overall care of Medicare beneficiaries

- Participating ACOs that meet specified quality performance standards eligible to receive share of any savings if actual per capita expenditures for assigned Medicare beneficiaries are sufficient percentage below specified benchmark amount
ACO Envisions Integrated Care

- Hospital
- Other Care Providers
- Payers
- Specialists
- Primary Care Providers

Patients
Research Context and Question

- Insurance company ("The Firm") partners with physician groups in several geographic locations to form Medicare Shared Savings ACOs (in 2012)

- The Firm had good experience with the Medicare Advantage (MA) managed care program

- ACOs viewed as a strategic opportunity

- What factors distinguish high-performing (ACO X, Y) from low-performing ACOs (ACO Z)?
Study Design: Mixed Methods

• Phase 1: analyzed CMS claims data on local ACO performance
  – measured performance in the calendar year prior to their entry into ACOs and the first year of ACO performance (i.e., data on cost, quality)
• Phase 2: intensive site visits to 6 ACOs: 3 top-performers; 3 lowest performers
• The main objective of site visits is to identify key factors that differentiate the high and lower-performing ACOs
  – Using primarily an inductive approach
Study Design, Phase 1: Measures of Cost and Quality

- Utilization (cost) measures:
  - Avoidable inpatient admission rates
  - Rates of readmission to an inpatient facility within 30 days of discharge
  - Emergency Department visit rates
- Quality measures from Healthcare Effectiveness Data and Information Set (HEDIS):
  - Diabetes
  - Congestive heart failure
  - Chronic obstructive pulmonary disease
Phase 1 Study Design (2)

- Overall performance score: the average utilization (cost) rank and average quality rank were calculated for each ACO, for both the first program year and change from baseline.
Phase 1 Results: Characteristics of High and Low Performers

- Both the low and high-performing ACOs had similar patterns of chronic disease and CMS risk scores (level of severity)
- The high performing ACOs had more members
- All high-performing ACOs had rates of avoidable costs that were below the average
- All high-performing ACOs improved performance on all study measures between the baseline and first year
Phase 1 Results (cont’d)

- All low-performing ACOs had higher costs on all measures that were above average

- All low-performing ACOs had decreased performance on all measures between the baseline and first year
Site Visits: Four Key Themes

• CMS may be using a flawed policy logic to drive change
  – Issues with timely data; financial incentives; defining membership in an ACO ("attribution")

• The logics ("mental models") of founders matter
  – ACOs vs. managed care

• The power of physician groups and their leaders matters
  – Physician leaders are still too rare

• How to build alliances with community providers and physician groups?
Theme 1: CMS as Weak Policy Entrepreneur

- Respondents describe problems with:
  - receiving timely claims data from CMS, especially in the early stages of the ACOs
  - the financial incentives/model
  - definition of who (Medicare beneficiaries) is an ACO member
Clinical Director, Corporate: When I first came here we didn’t have any data. Our information comes from CMS as far as paid claims goes and we wouldn’t get claims for three - four months at a time. A couple of times in this spring they sent us data that they shouldn’t have sent, so it all had to be destroyed and then we had to start all over again.
Physician Board Chair, NE Region: They (CMS) need to fix the financing. Currently the cards are so stacked against us to make this thing make money. It is brutally, brutally hard. And when you’ve got smart people [forming ACOs around the country], you’ve only got a 30% success rate of MSSP ACOs in savings, that should be a pretty damning statement and the government should not to be touting this as some kind of success story.
Executive Site Director, NE Region: **There is an adverse selection bias under retrospective attribution and it’s not good.** It’s negatively impacting our 2013 results. CMS has got fix it. **They are saying, on top of doing all this other stuff and investing 2 million bucks a year to do it, you also need to run a wellness campaign to make sure everybody on your preliminary prospective list stays with you during the year, and that is a huge operational campaign.**

“They need to fix the attribution model because we are losing cheap patients.”
Theme 2: Founder Effects and The Firm’s Slow Start

• The Medicare Advantage (MA) blueprint and its success for the Firm loom large in the founding of its ACOs, particularly for the top managers who launched the ACO effort and who had been responsible for MA plans.

• Corporate MA President: We started here in the marketplace with our Medicare Advantage plan, and the model was really aligning and engaging with primary care physicians and giving them the necessary tools. Most plans don’t share that information in a positive manner with physicians. Then when ACA came out, we realized, hey! This is very much that we done for so many years successfully - engaging and aligning with physicians.
But, what is needed to launch an effective ACO differs substantially from the MA model of managed care which has:

- a fixed panel of patients;
- access to timely information about these patients;
- immediate provider engagement due to the structure of financial incentives

• Failure to recognize this seems to have hurt top managers’ ability to see the slow start for their ACOs
• …new managers were brought in who immediately changed the Firm’s approach to providers
Theme 3: Physician Groups and Their Leaders

• Early literature suggests that it is critical to build an ACO on the foundation of a strong, well-organized physician group
  – ACO X and Y’s performance supports this view
  – The physician groups in these ACOs are relatively large and well-organized and, in particular, they use electronic medical records (EMR) quite well

• In contrast, ACO Z involves 5 separate physician groups that do not have a common EMR
Physician Leaders (2)

• Both physician groups (ACOs X,Y) have effective and long-serving leaders

• Why do physician leaders matter so much?
  – local physicians often have years of experience in their communities
  – have gained the respect of peers for their commitment to providing high-quality care
  – …and for their interest in helping to organize other physicians …but they are rare
Theme 4: How to Build Effective Community Healthcare Alliances?

• The Firm’s strategy is not to include high-cost providers (hospitals, multispecialty medical groups) in an ACO
  – But, still a great need to work effectively with such providers, e.g., to get information on patient flow such as hospital discharges
Effective Alliances with Non-ACO Hospitals: High vs. Low-Performing ACOs (X,Y v. Z)

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<tr>
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<th>MD Group Power (leadership)</th>
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<th>Medicare Financial Incentives</th>
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<tr>
<td>ACO Y</td>
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<td>ACO Z</td>
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Hospitals currently cooperating with ACOs appear to do so because of a combination of:

- financial incentives from Medicare
- power of physician groups
- a sense of community among providers, history
Selecting Partners for the Dance: Pros and Cons of a Strong Physician Group

Pros

• Can leverage power with non-ACO actors

• Are already high-performers on cost, quality
  – Strong physician leaders
  – Strong IT/EMR

Cons

• Reduced opportunity to make profit under CMS model

• Strong groups can more easily leave the partnership

Alliances with physician groups are fragile!
Building Alliances with Physician Groups (2)

• Because the role of effective physician leaders is so critical, much more attention needs to be given to developing physician leaders in each ACO…(e.g., ACO Y has only one real physician leader)

• But, are there perverse incentives that could keep the Firm from doing this?
Implications for Policy-Makers

- CMS needs to re-think its founding logic: provide incentives to improve quality and lower cost, but *never say or look like “managed care”*...is this working?

- Current design does not enable timely data to coordinate care
- Penalty for cost-effective providers?
- Need to adapt, while avoiding “policy capture”
Managerial Implications

- Beware your mental models!
  - Does “Success breed failure” for the Firm? --
    success in Medicare managed care provides a mental model, blueprint, script for ACOs, but hinders their early performance

- Strategic alliance skills are at a premium

- Beware policy traps; policy advocacy at a premium too
The Road Ahead: Effective ACOs

- Strategic selection of partners and managing non-partners
- Getting the incentives right
- Engaging and activating patients/healthy non-patients
- Effective care coordination technologies that involve social work
- Leadership, especially physicians
- Effective IT/EMR systems
The Road Ahead (2)

- History and power of the logic of professional autonomy, coupled with perverse financial incentives, have promoted:
  - Low sense of individual responsibility for health and cure
  - Lack of well-developed technologies for care coordination
  - Low capability for social problem-solving (vs. medical)—little coordination between the health care and social service fields/sectors
The Road Ahead: Three Logics that Must Be Developed

- Population health and social welfare
- Community
- The physician as servant leader and team member
  - (UT, Austin Dell Medical School?)
Why Won’t Followers Follow?

“There is nothing more difficult and dangerous, or more doubtful of success, than an attempt to introduce a new order of things in any state. For the innovator has for enemies all those who derived advantages from the old order of things while those who expect to be benefited by the new institutions will be but lukewarm defenders…”

Machiavelli, *The Prince*
Thank you!