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Healthcare

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The Leading Edge

ACO model should encourage efficient care delivery

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ARTICLE INFO

Article history:

Received 11 April 2015

Received in revised form

11 June 2015

Accepted 15 June 2015

Available online 23 July 2015

Keywords:

Accountable Care Organizations

Pioneer ACO

Payment redesign

Risk adjusted global

ABSTRACT

The independent Office of the Actuary for CMS certified that the Pioneer ACO model has met the stringent criteria for expansion to a larger population. Significant savings have accrued and quality targets have been met, so the program as a whole appears to be working. Ironically, 13 of the initial 32 enrollees have left. We attribute this to the design of the ACO models which inadequately support efficient care delivery. Using Bellin-ThedaCare Healthcare Partners as an example, we will focus on correctable flaws in four core elements of the ACO payment model: finance spending and targets, attribution, and quality performance.

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1. Essential elements for the success of the ACO model

The Centers for Medicare and Medicaid Services (CMS) announced results from the second year of the Pioneer Accountable Care Organization (ACO) Model and Medicare Shared Savings ACO Program last fall [1]. In addition, CMS recently announced that the independent Office of the Actuary for CMS has certified that Pioneer model has met the stringent criteria for expansion to a larger population. Given the overall savings that are beginning to accrue and the quality targets being met, the program as a whole appears to be working. Ironically, many of the enrolling organizations are exiting the Pioneer program (13 of the initial 32 enrollees have left). We attribute this to the design of the ACO models. The models do not adequately support efficient care delivery. We expect even more of the efficient care ACOs to exit these programs over the next few years. Using Bellin-ThedaCare Healthcare Partners as an example, we will focus on correctable flaws in four core elements of the ACO payment model: finance spending and targets, attribution (assignment of the patient population), and quality performance. Despite the recent announcement of the Next Generation ACO model, these elements have yet to be adequately addressed. CMS should make significant structural

changes in how these promising programs operate, or the ACO model will be perceived as a failure.

2. Financial flaws

2.1. The current fee-for-service (FFS) structure

High cost ACOs have more opportunity to share savings than low cost ACOs in the existing Pioneer and CMS ACO programs. There is more opportunity for Medicare in high cost ACOs too. For example reducing the cost for 20,000 Medicare beneficiaries by 5% in a market with per capita spending of \$15,000 a year delivers dollar for dollar significantly more savings than a market where spending is at \$8000 a year. Consider the Bellin-ThedaCare (BT) Healthcare Partners ACO—the Pioneer ACO that had the lowest baseline cost after the first year of pioneer (\$8030 per year) but that still managed to deliver Medicare savings and the highest quality scores in the second year albeit with less shared savings produced in the second year. There is a point of no return on the shared savings model which BT is rapidly approaching. As previously reported, BT redesigned the process for chronic illness management, to prevent the need for 500 Medicare admissions in 2012, thereby reducing ThedaCare's revenue by 0.7% during the first six months of that year [2]. The problem is that BT's fixed costs still remain. In addition, the design and implementation of

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new care processes to avoid redundant hospitalizations, office visits, and tests did not come free. Better coordination of chronic illness services, though less expensive than sick care, is not paid for in the current FFS environment [3]. In contrast high cost ACOs have more upside with shared savings which can be applied to new infrastructure. Although the Next Generation Model considers efficiency in the discount rate that is applied to the target and lowers the discount rate for low cost ACOs, the target is still based off of the low baseline costs and the fundamental problem still remains—low cost organizations are penalized for the work they have already accomplished.

2.2. Inconsistently set targets

High cost ACOs are already starting with an advantage over low cost ACOs. But in addition in 2012, the Pioneer payment formula revealed a critical flaw that further penalizes low cost ACOs when national cost trends decrease: the lower the ACO's starting cost, the greater savings it must achieve to receive shared savings. When the trend drops below zero, low cost ACOs have to beat the target by a larger percentage than the national trend and high cost ACOs have an easier target compared to the national trend. For example, in year one, the national cost trend for BT's reference population was -1.7% ; and, BT had to reach a -1.9% target. Conversely, a higher cost Pioneer ACO (also with a -1.7% reference trend) received an easier -1.4% target.

This flaw can be easily fixed by setting the benchmark consistently so that high cost systems always have a challenge in meeting it. The same relative adjustment to the target should occur in the same direction regardless of whether the initial environment is inflationary or deflationary. The MSSP program contains a formula flaw similar to Pioneer. If CMS does not address the current target-setting process, many low cost providers in the program will find participation untenable. The Next Generation Model addresses this by setting the target more consistently. The same practice should be applied to other ACO models.

2.3. Inaccurate baselines

Reducing costs requires investment, as BT made in reducing hospitalizations. The problem in the Pioneer program is that CMS does not recognize these additional costs. This may work within a single year, because shared savings may be greater than the investments made in care coordination and prevention. Over time, however, CMS plans to reduce the target amount to the new level of FFS costs without including the additional costs, effectively not paying for ongoing coordination costs. Without adjustment to the baseline to account for these costs of care, care improvement efforts will be seriously underfunded. A similar problem exists in MSSP. Next Generation has acknowledged this issue but has not yet proposed a concrete solution.

2.4. Attribution flaw

2.4.1. Reliance on claims alone

Currently, the attributed population does not accurately represent the treated population which affects how costs and savings are calculated and how we think about managing a population in general. In Pioneer, all participants experienced significant turnover in attribution from the first year to the second (the mean was 32%). During its first two years as a Pioneer ACO, BT saw new and existing patients move in and out of the attributed population at a much higher rate than mere changes in the patient's primary care provider (PCP) would cause. Less than 8% of the population changed PCPs in the first two years according to the CMS patient surveys, yet 28% of the

attributed population turned over. BT's true patient population is estimated to be perhaps 50% larger than the population attributed to it in any given Pioneer year.

Whether or not the attribution methodology can be improved is unclear. CMS has implemented attestation methodology into Pioneer and Next Generation which reduces churn slightly but the solution does very little to address the core problem of identifying patients' current care relationships. For now, CMS should allow all beneficiaries to identify their PCPs, and it should include that information in the algorithm to assign beneficiaries to ACO practices.

3. Quality-performance flaw

3.1. Metrics and benchmarking

Improving the quality of care should be front and center in the redesigned ACO program. Current quality metrics—which are inadequately defined, change rapidly, and derive benchmarks from faulty data sets—do little to improve quality. Benchmarks must be accurate, meaningful, and achievable. National consistency on metrics is the current goal, but local and regional efforts to measure quality are emerging as the best alternative for comparisons within some individual states [4]. Any measurement of quality should include core sets of metrics that are applicable to population health and might vary by market. Metrics must be clearly defined, consistently measured, and accurately benchmarked. In addition, ACOs must employ rigorous systems of improvement to improve care. ThedaCare's improvement methodology is one example of such a system and has been well documented [5].

4. Recommendations

4.1. Adopt a risk-adjusted global payment model

As the ACO performance improves there is a point when a new payment model is required. BT is at that point. CMS has presented the Next Generation ACO model that contains incremental improvements including options for global payments but continues to reward improvement over baseline and does not reward absolute achievement of low cost and high quality. It is entirely possible that a low cost ACO participating in Next Generation could achieve the lowest cost and highest quality but be financially worse off than if they did not participate at all. Using historical performance to establish baseline continue to penalize providers that have spent years improving care without rewards. CMS should establish a new ACO program that incorporates a new payment model defined by the actual per member per year (PMPY) experience in the ACO's base year, adjusted for the population risk and for regional differences in wages and non-labor inputs. The baseline should also be adjusted for efficiency. This system should accurately account for the total cost of care (as discussed above). In this payment model the reward will be achieved by either improving or achieving efficiency. CMS should hold ACOs accountable for improving or achieving preset quality and service targets. Assuming these targets are met the ACO can distribute the payments to physicians, hospitals, and other relevant providers in a way that best achieves improved health outcomes for Medicare beneficiaries.

We realize that less-efficient healthcare systems are unlikely to accept such an ACO payment model. But we believe that many efficient systems such as BT will embrace the option. It is critical that an option be created for the efficiently performing ACOs in order to keep the proven leader ACOs involved and collaborating

around improvement.

4.2. Other needed changes

In a global payment model, an ACO is now at full financial risk. Secondary reinsurance, preferably provided by CMS, would be helpful to account for catastrophic and some other types of insurance risk for providers with small attributed populations or whose reserves are slim.

In addition, real-time Medicare claims data should be readily available in its entirety to ACO participants. The lag in information flow for Pioneer ACOs has been frustrating because the data is critical for identifying and improving patient outcomes. When an ACO doesn't have timely complete information, it cannot be proactive about improvement efforts nor avoid flaws before they become too entrenched.

5. Conclusion

The ACO models as they stand today reward high cost ACOs and penalize low cost ACOs. The Pioneer program has given us valuable insights into how to align incentives to restructure the US healthcare system. However, CMS's policies must better support its goals. The Next Generation Model has incorporated some welcome changes but does not go far enough to address the issues raised. To be fair, there are elements of the program yet to be defined that may further address some of these concerns. We believe that CMS needs to structure the program better in order to encourage the participation of highly efficient high quality ACOs. The changes we propose would significantly strengthen the ACO programs, contribute to dramatic cost reductions, and improve quality for Medicare beneficiaries. That would be a win for the government, providers, and patients.

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Conflict of interest disclosure statement

This statement accompanies the article "ACO Model Should Encourage Efficient Care Delivery, co-authored by John Toussaint, MD (Corresponding Author); Co-authors: David Krueger, MD, MS, MBA; Bellin-ThedaCare Healthcare Partners, Stephen M. Shortell, PhD, MPH, MBA; US Berkeley School of Clinical Excellence Research Center, Arnold Milstein, MD; Stanford, Stanford Clinical Excellence Research Center; MPH, David M. Cutler PhD; Harvard University, Department of Economics, Harvard University, and NBER; Stanford, Stanford Clinical Excellence Research Center and submitted to Healthcare as an original article. Below all authors have disclosed relevant commercial associations that might pose a conflict of interest (if none, please write None):

Consultant arrangements: None
 Stock/other equity ownership: None
 Patent licensing arrangements: None
 Grants/research support: None
 Employment: David Krueger, MD, MS, MBA; receives a salary from Bellin-ThedaCare Healthcare Partners.
 Speakers' bureau: None
 Expert witness: None