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Accountable care payment

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For the Honolulu Subarea Health Planning Council of the Hawaii SHPDA

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Agenda for the presentation

- Describe major forms of accountable care payment
- Identify key design options
- Outline Medicare's programs
- Review progress to date in Hawaii

The problem

- Fee-for-service payment does not encourage high quality or efficient use of services
- Pay-for-performance an interim step
- New payment model needed to incent providers to:
  - Provide right mix and sequence of services
  - Coordinate delivery of care with other providers

Goal of accountable care payment

. . . To drive improvements in the quality and efficiency of health care deliver by:

- Aligning the incentives of physicians and hospitals
- Improving providers' processes and coordination in delivering care

What is an accountable care organization?

. . . a collaboration to assume responsibility for overall patient care, across providers and settings

- Hospital and affiliated physicians are core groups
- Collaboration can take many forms

Progression of accountable care payment options

	Patient centered medical home	Bundled payment	Full ACO model
Focus	Primary care	Primary and/or specialty care	All care
Unit of payment	Hybrid of: – Per service – Per capita	Per episode	Per capita (defined population)
Status at HMSA	Being implemented	Consider pilots	Consider pilot or transition from bundled payment

Patient-centered medical home

- Over 50% of HMSA's members are in a patient-centered medical home
- A medical home serves as a central resource for patients' ongoing care:
  - Provides a broad spectrum of care, both preventive and curative
  - Coordinates all care patients receive

Key features of a medical home

- Every patient has a primary care practitioner (PCP)
- PCPs work as a team with other professionals (such as diabetes counselors and dieticians)
- PCPs and staff communicate by phone or email to minimize in-person visits
- Practices use EMRs to identify gaps in care
- Practices reach out to patients to alert them to recommended screenings and discuss health trends

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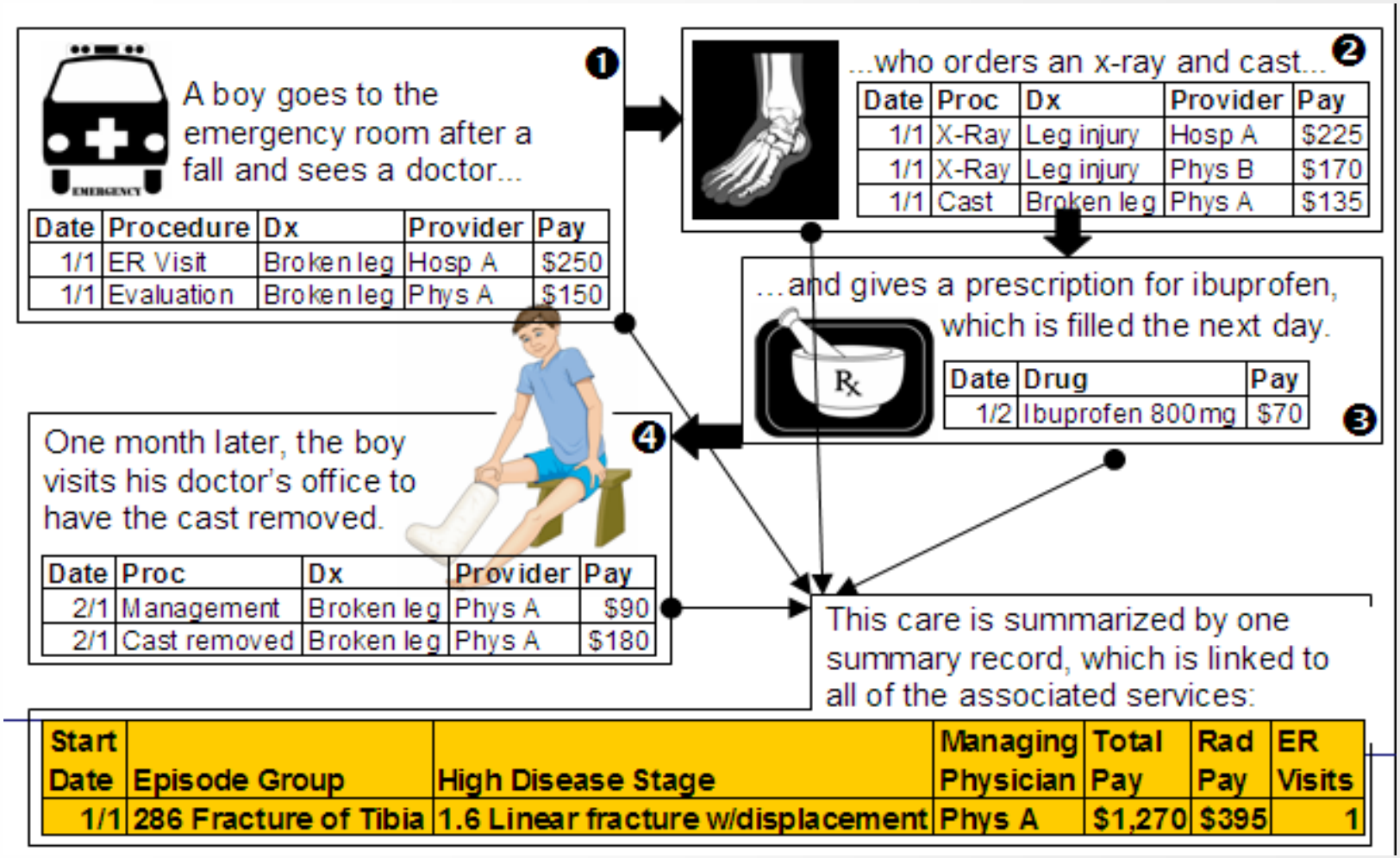
Example of an episode of care



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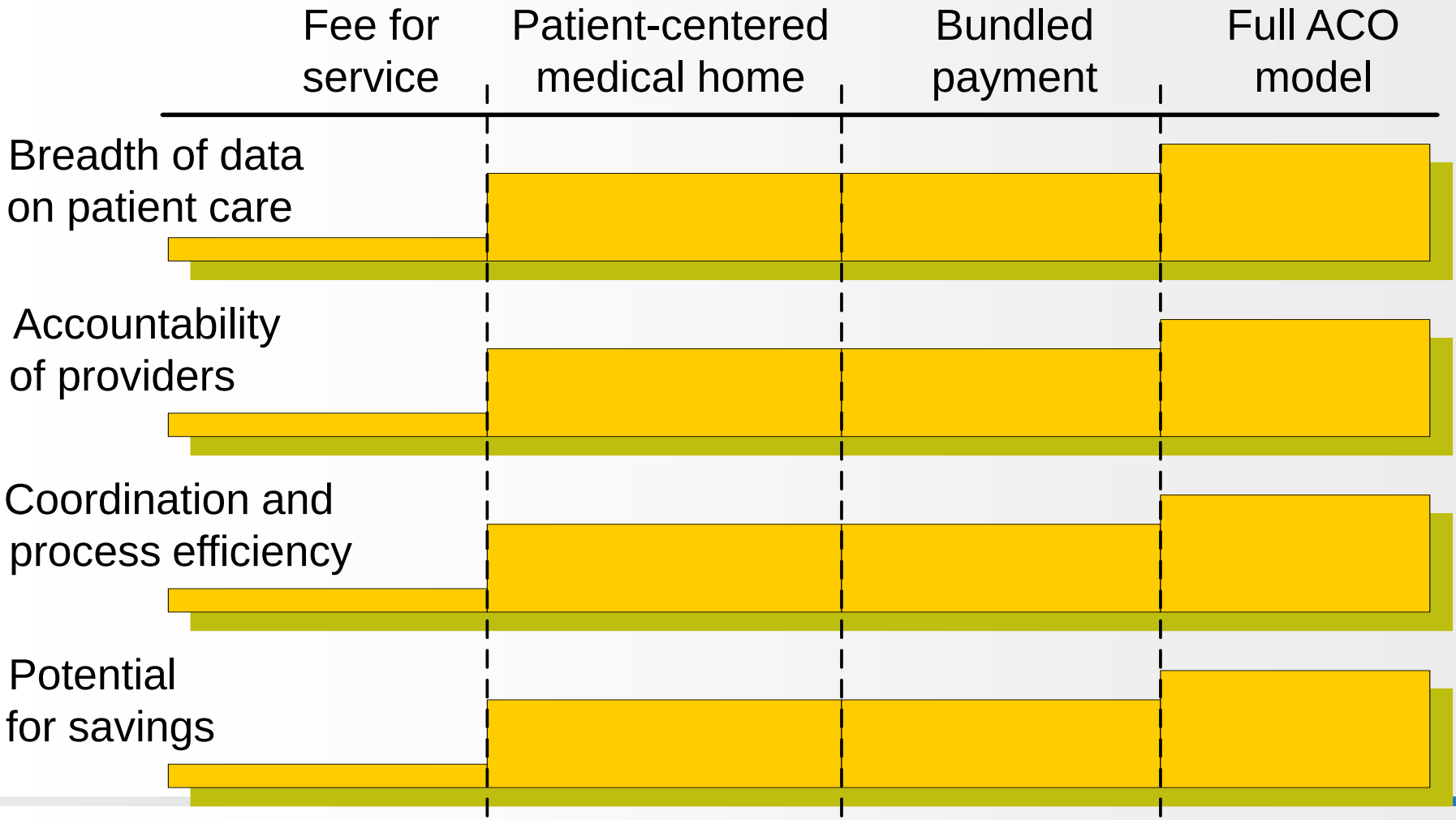


Comparison of ACOs and HMOs

Factor	ACO	HMO
Incentive for ACO/HMO	Improve quality and efficiency outcomes	In practice: Restrict services
Member must commit to a PCP	No	Yes
PCP must approve referral to specialist	No	Yes
Member assignment	Member uses PCP affiliated with ACO	Member selects HMO

Key decision points in accountable care payment

1. Clinical domain
2. Payment structure (shared savings vs. epidsode payment rates)
3. Length of episode
4. Services covered
5. Treatment of quality

Design decision—clinical domain

Oriented toward episodes:

1. Surgical procedures
2. Chronic conditions
3. Conditions that may require surgery

Oriented toward per capita (ACO model):

1. A medical specialty
2. All care

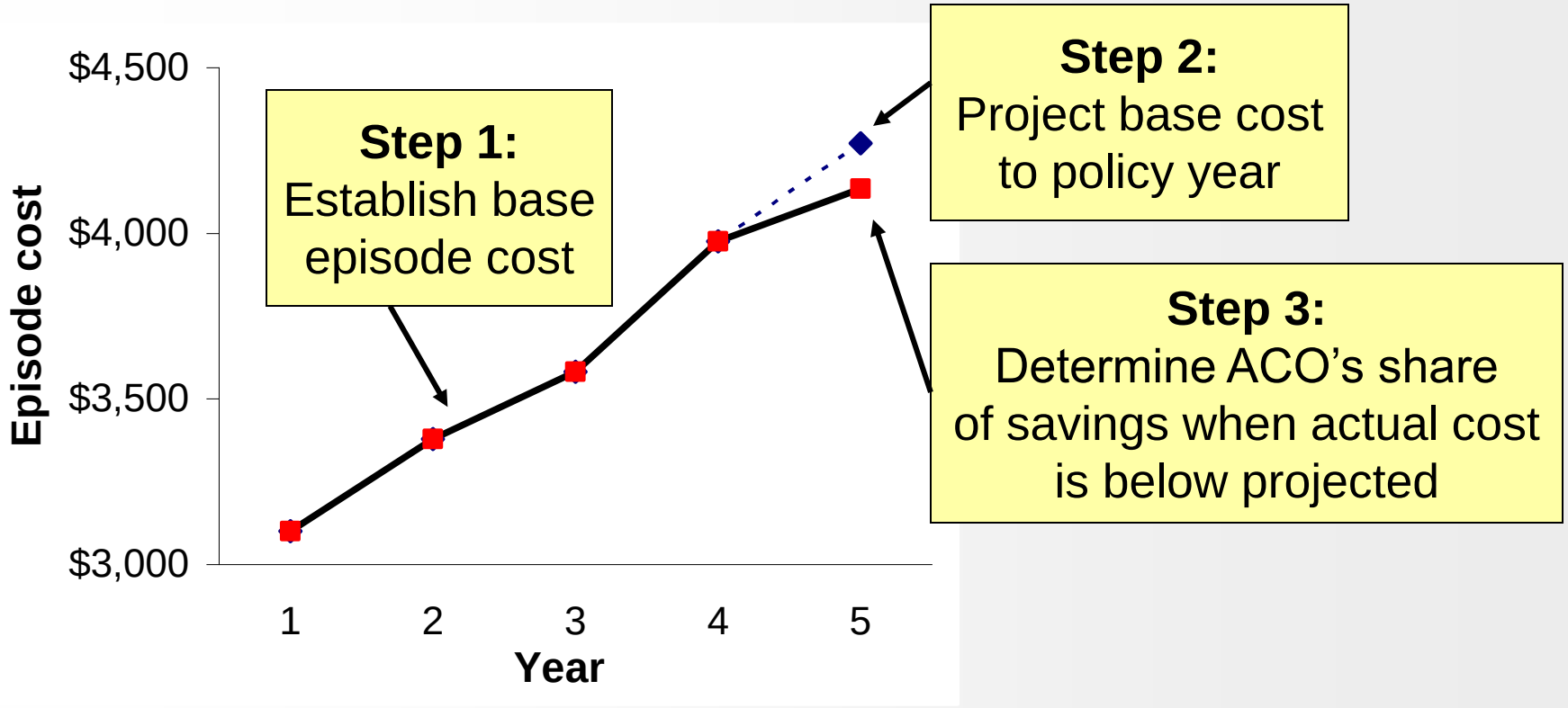
Design decision—payment structure

1. Maintain FFS rates, with shared savings to control episode costs

2. Create fixed payment rates for episodes or all care

Fixed rates raise the stakes for provider groups and payer alike

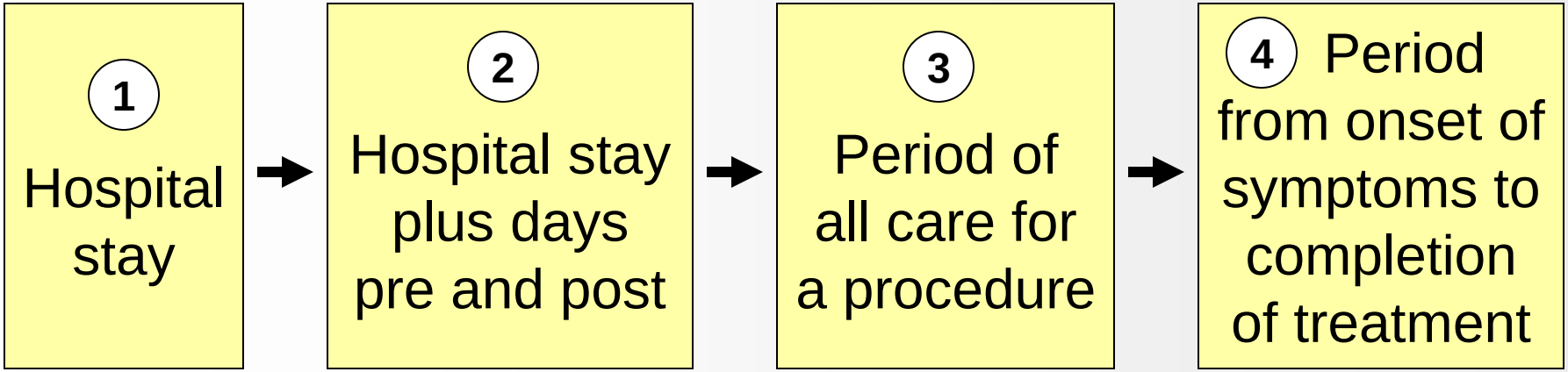
Steps in shared savings arrangement



Decision needed on sharing losses as well as savings

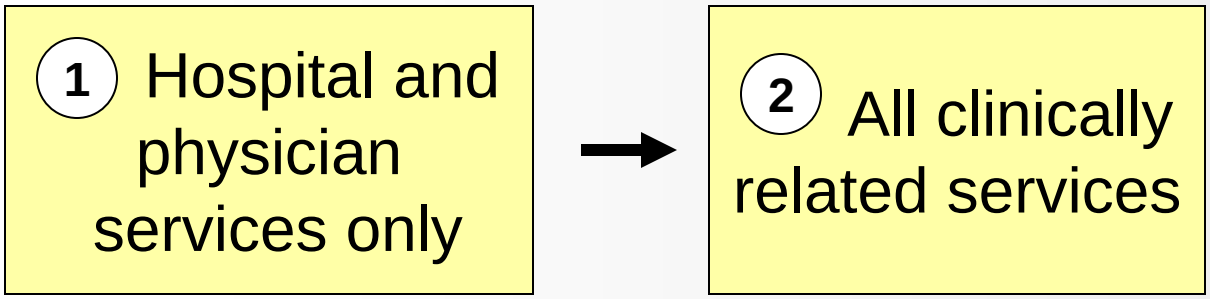
Design decision—length of episode for payment

Four options progress from subset to full episode



Moving across options increases complexity but also potential for savings

Design decision—services included



- Might initially limit bundled payment to hospital and physician services
- Add other services over time—SNF, rehab, mental health, hospice, etc.

Design decision—treatment of quality

1

Shared savings on both cost and quality metrics

3

- Shared savings on cost only
- Minimum quality standards to qualify for reward

Readmissions: optimally included in episode, not just as quality metric

Medicare's programs

1. Acute Care Episode (ACE) demonstration
   - Launched in 2009
   - Initially covered hospital stays—may be extended to post acute care
2. Shared savings program (for ACOs)
3. ACO pioneer program
4. Bundled payment program

Medicare's Shared Savings Program

- Open to any qualified provider group (not a demonstration)
- First round of implementation planned for 4/1/12

Key features of Shared Savings Program

- Patients attributed to ACO when a plurality of their primary care provided by ACO physicians
- Attribution invisible to beneficiaries—no restrictions on patients' choice of providers
- ACO must generally have 5,000 assigned beneficiaries

Key features of Shared Savings Program (continued)

- Spending targets based on 3-year trend of assigned beneficiaries' costs
- ACOs can initially choose to:
  - Share in savings only (up to 50%)
  - Share in savings and losses (up to 60%)
- For ACO to qualify for shared savings:
  - Savings must exceed a minimum of 2% or more
  - Minimum quality threshold met on 70% of measures

ACO Pioneer program

- Designed for provider groups experienced in coordinating care across settings
- Both losses and savings shared with higher levels of sharing and risk
- Population-based payment in third year—hybrid of FFS and fixed per capita amount

Medicare Bundled Payment for Care Improvement Initiative

- Providers propose the clinical conditions to be covered using MS-DRGs
- A target episode cost developed by applying a negotiated discount to projected episode costs
- Providers keep all or a portion of savings if actual episode costs are below target

Four Medicare bundled payment models

Model	Episode definition	Payment structure
1.	Inpatient stay only	Shared savings
2.	Inpatient stay + up to 90 days post-discharge	Shared savings
3.	Post discharge only	Shared savings
4.	Inpatient stay only	Fixed episode rate

Accountable care payment in Hawaii

- HMSA's progress:
  - Pay-for-quality implemented for all major hospitals and all PCPs
  - Half way to goal of all members in a patient-centered medical home
- No providers in Medicare or private sector ACO or bundled payment programs to date
- HMSA open to pilots with provider groups

Factors in limited ACO and bundled payment response to date

- High HMO penetration (54%–highest in nation)
- HMSA's payments already partially bundled
- Limited use of SNF, home health, and inpatient rehab as part of surgical care
- Hospital/physician integration limited beyond Kaiser