Accountable Care Organizations: A Brief Overview and Evaluation

Board of Administration Offsite

July 16, 2019

Accountable Care Organizations: A Brief Overview and Evaluation

Goals:

- Overview and history of ACOs in the Marketplace
- CalPERS experience with ACOs
- Looking to the Future

Accountable Care Organizations: A Brief Overview and Evaluation

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Accountable Care Organizations: What is the Evidence?

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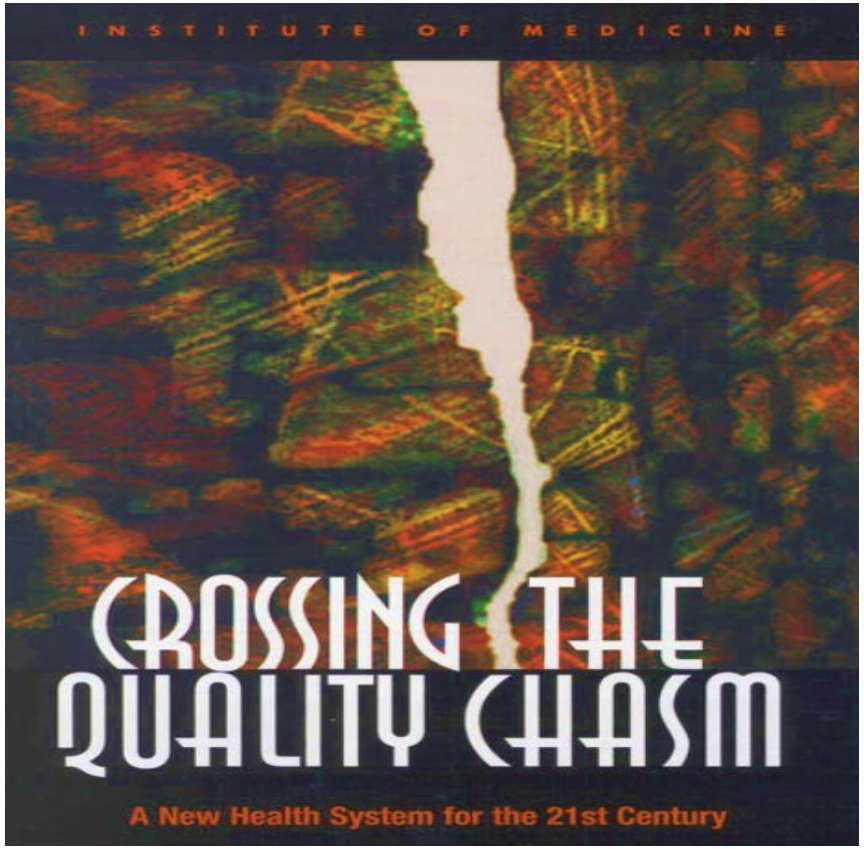
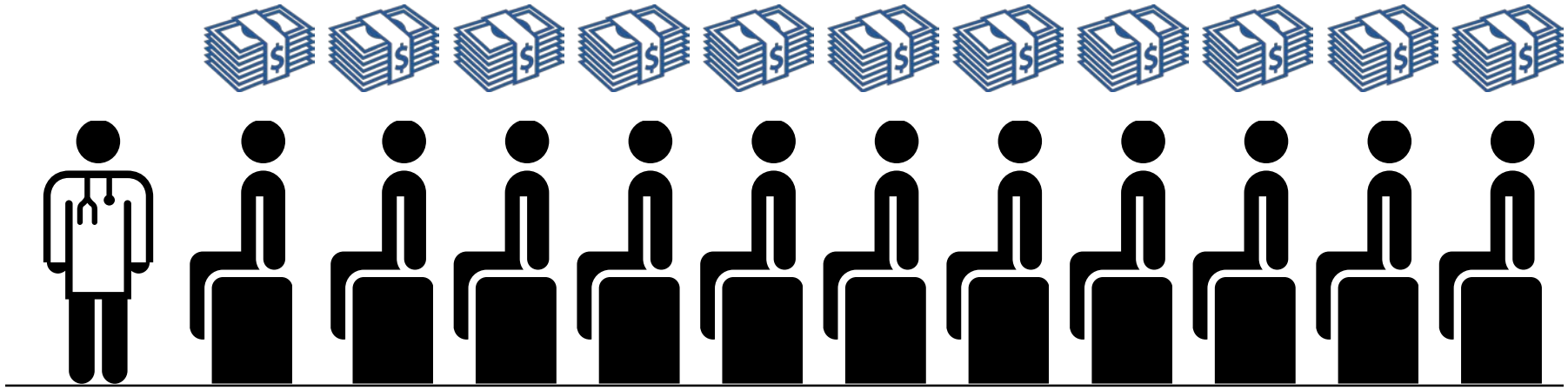
In 2000, the Institute of Medicine signaled a crisis in American health care



Shifting health care payment models to produce value

A change was needed

How fee-for-service payments work



Pays physicians based on the volume of services they provide

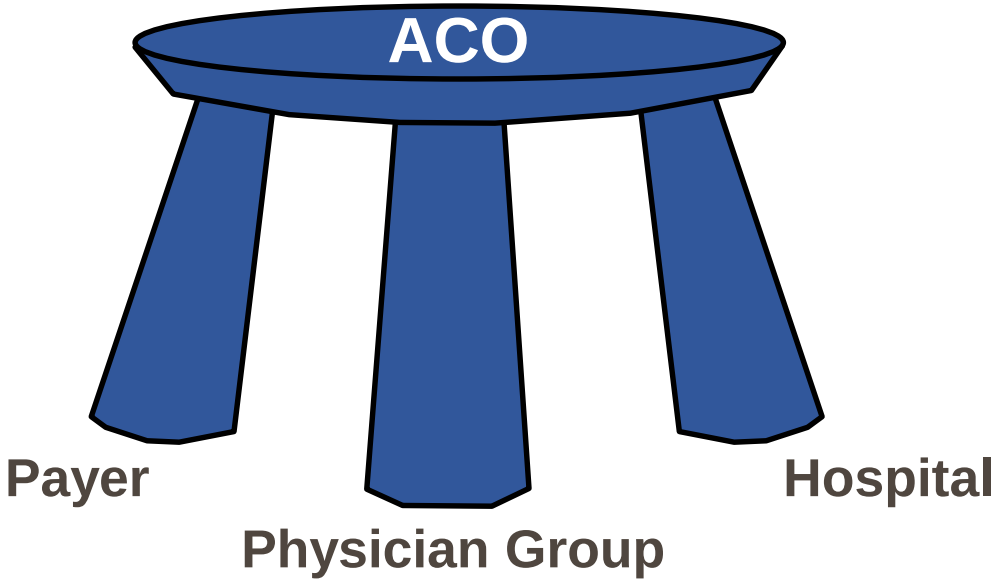
Payments not contingent on quality, safety, patient experience or use of resources

How pay for value works

Financially rewards providers who achieve high performance on both patient outcomes and cost of care

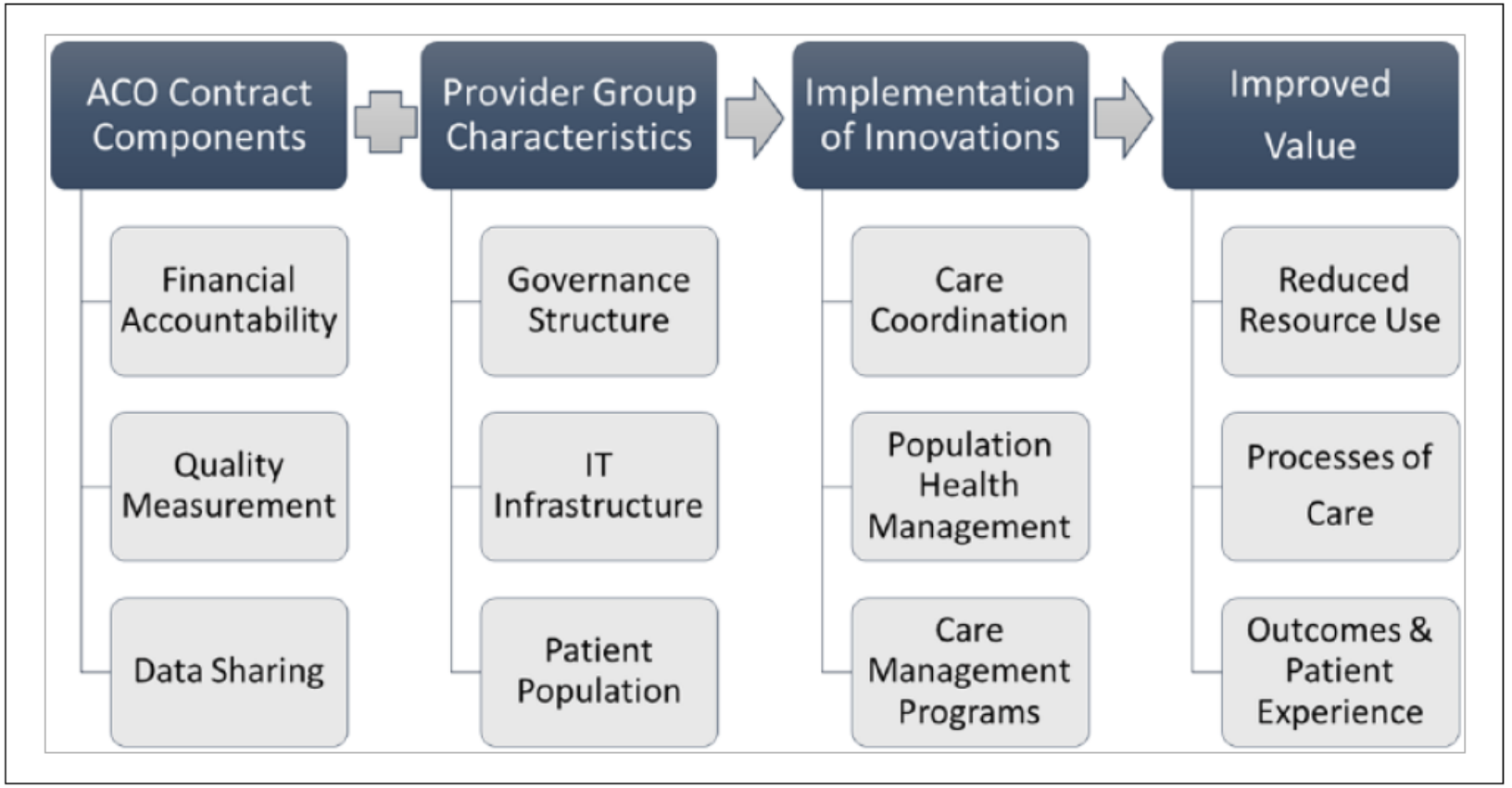
What is an Accountable Care Organization (ACO)?

A partnership between a payer and its providers designed to improve health care quality and outcomes, while reducing total cost of care for a defined ("attributed") patient population



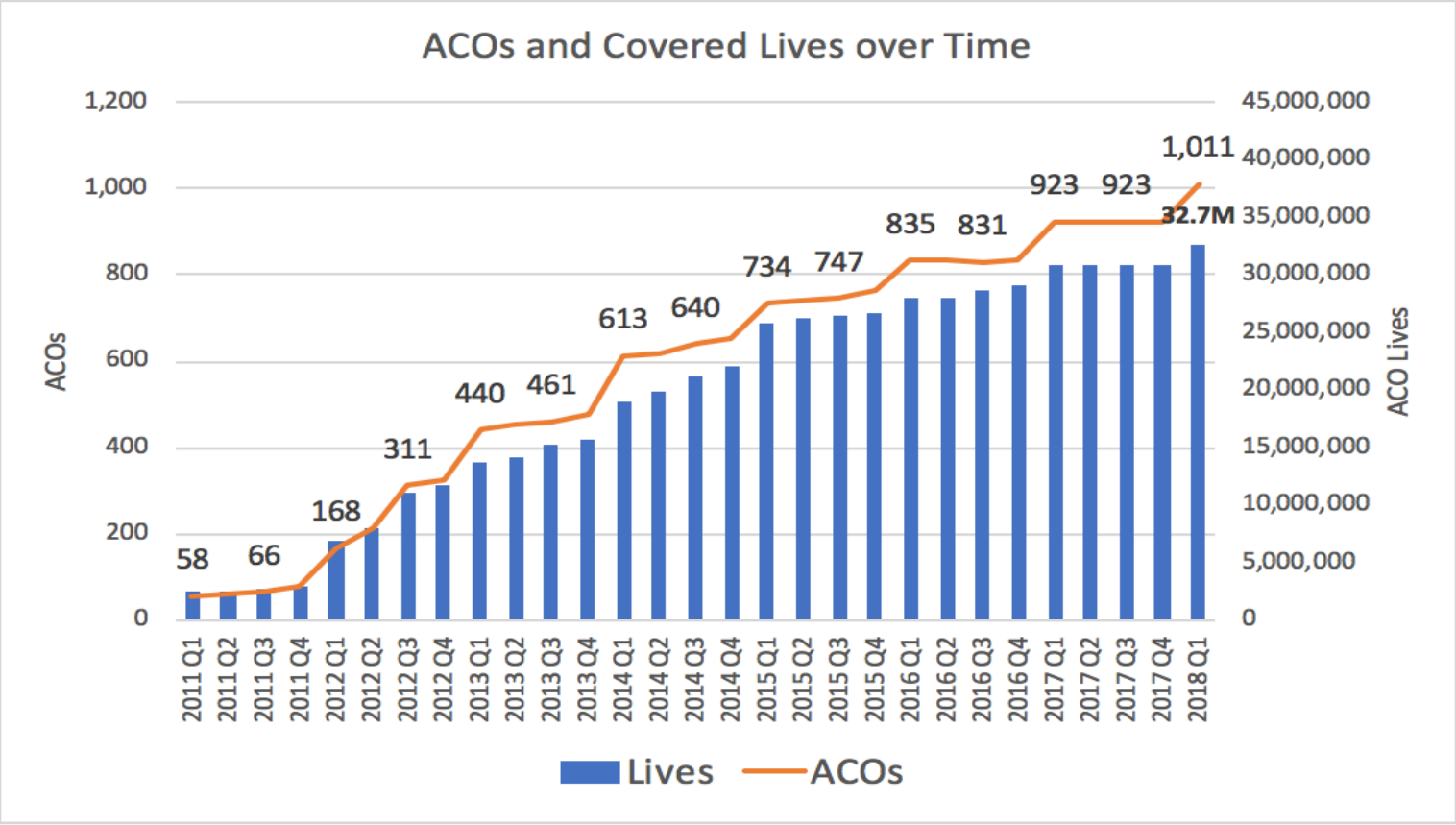
Built on existing HMO or PPO chassis

A model for how ACOs work



Source: Kaufman et al., Impact of Accountable Care Organizations on Utilization, Care and Outcomes: A Systematic Review. *MCRR*, 2017

Significant growth in ACOs since 2011

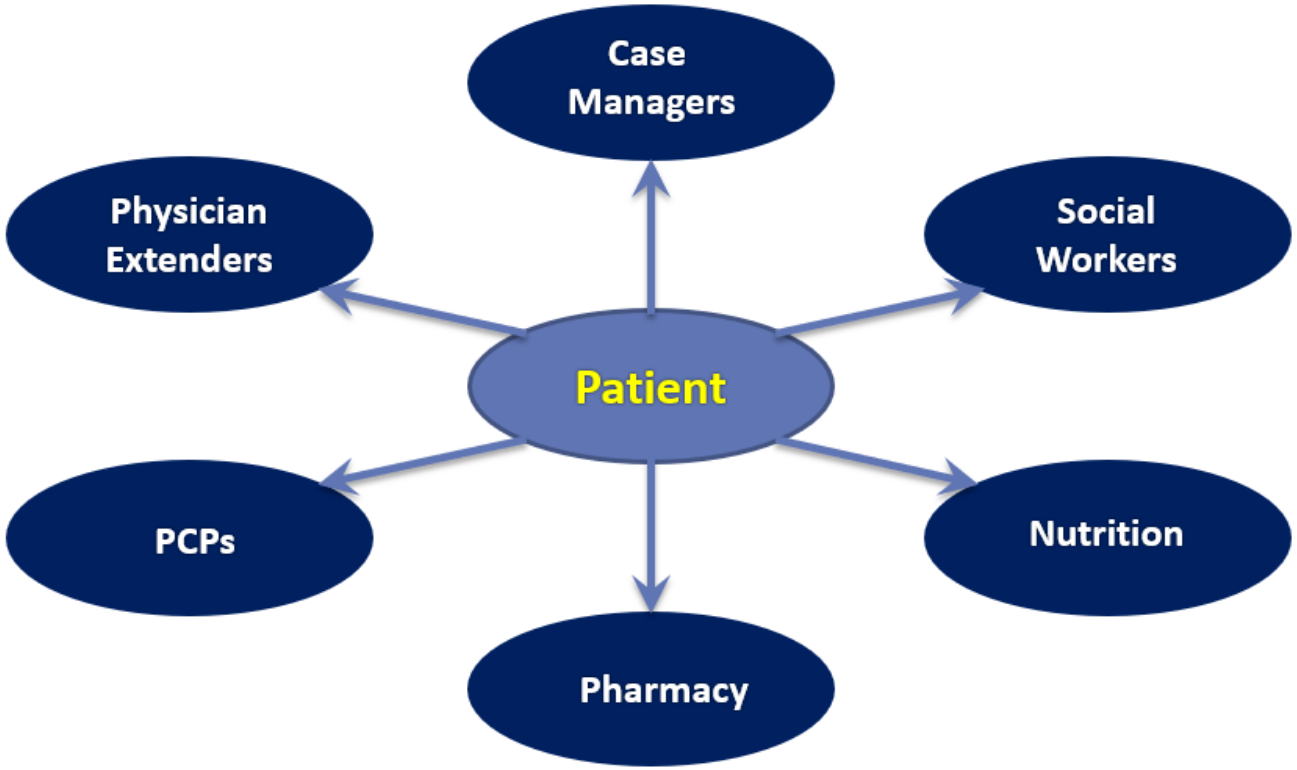


Source: Muhlestein et al. (2018). *Health Affairs Blog*.

What actions are ACOs supposed to drive?

- Increased data sharing between the payer and its providers
- Improved care coordination across the care continuum
- Improved transitions between care settings
- Reduced waste and duplication of services
- Management of population health

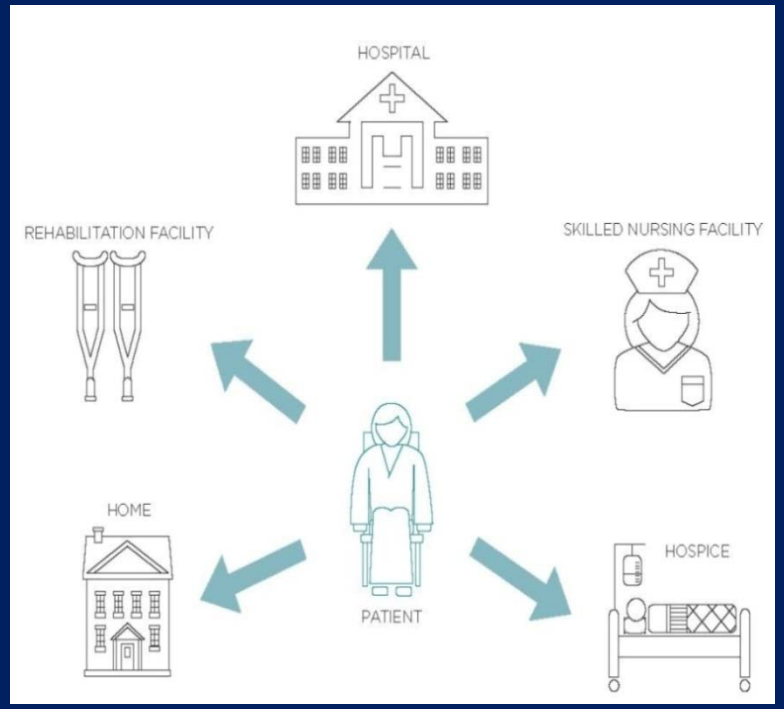
Example: Care redesign to coordinate care for complex patients



Example: Managing transitions in care

MANAGING TRANSITIONS IN CARE:

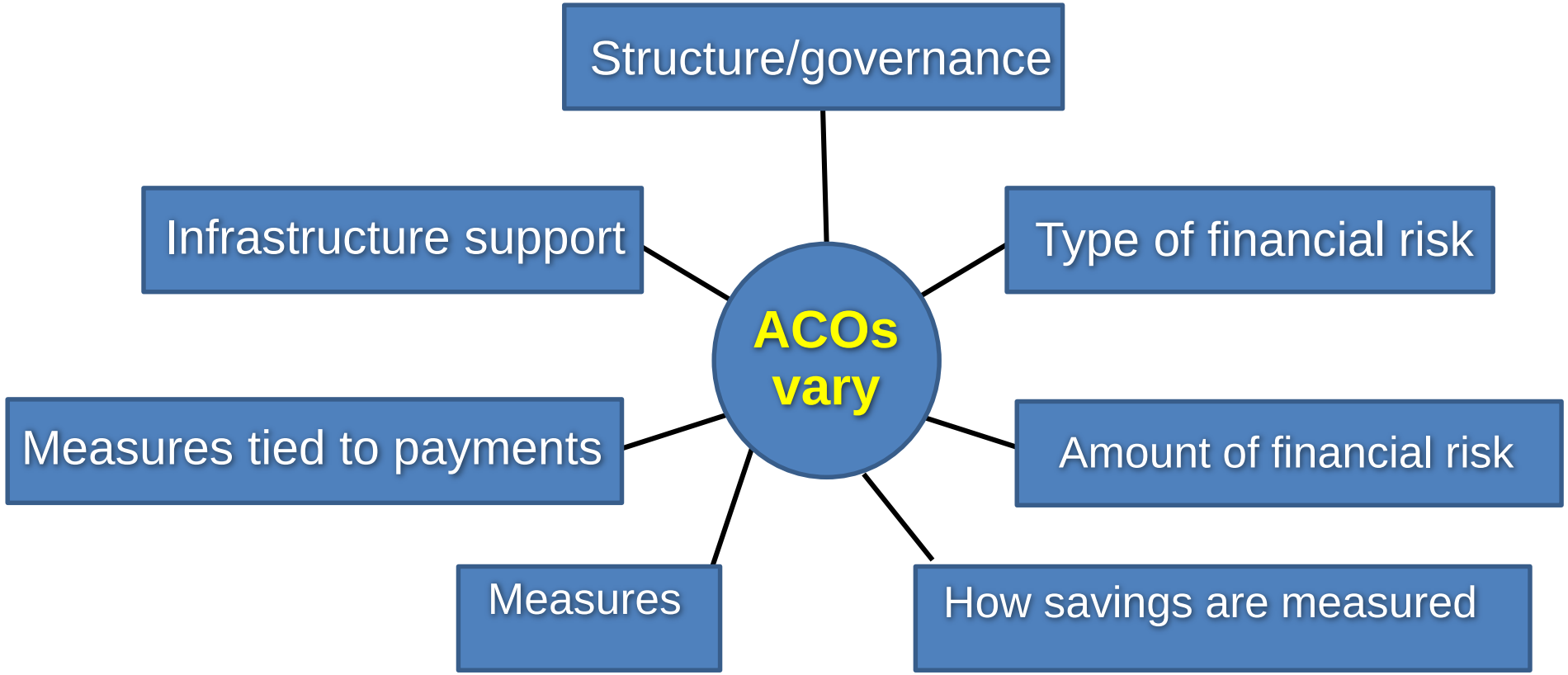
- Care coordination in order to prevent unnecessary admissions and ED use, and prolonged hospitalization
- Formal discharge planning interventions
- Interventions to guide the patient from the ED to the hospital or back home



What is the evidence on ACO effects?

- Majority of studies focus on evaluations of Medicare ACOs
- Small number of studies on commercial ACOs
  - Massachusetts Alternative Quality Contract (AQC)
  - CalPERS ACO
- **Key problem** – commercial payers reluctant to have an independent evaluation of their ACOs and publicly share the results
- Savings assessment - saving compared to what? What is the right counterfactual?
- Study findings are mixed, need to be unpacked, and understood in context of specific ACO being implemented

As we consider effects, ACOs vary in important ways that can affect results



How have providers within ACOs respond to new incentives?

- Worked on the “data”
  - Presentation and organization of data
  - Predictive modeling to identify patients at risk
- Investment in clinical processes (enforce standards of care)
- Improve hospital discharge planning
- Shift care to lower cost settings and providers
- Increase use of palliative care
- Creation of integrated teams for managing complex patients
- Medication reconciliation

An Evaluation of Accountable Care Organizations

David Cowling

Assistant Division Chief

Health Innovation and Pilot Performance

CalPERS

Background

- Accountable Care Organizations (ACOs) are health care organizations that are responsible for financial and quality outcomes for a defined population across the continuum of care

- Promise
  - Better coordinated care and health management leading to higher quality care and lower costs

- Growth
  - 1000+ ACOs in U.S. with 32 million covered lives

Background: CalPERS and ACOs

Expand integrated health management models

- 2014 - 2018 health plan contracts

Continue to iterate ACO models

Participated with:

Integrated Health Association & Catalyst for Payment Reform on standardized ACO reporting

Background: Sacramento Region ACO

- Partnered with Blue Shield of California, Hill Physicians Group, and Dignity Health in 2010 on a commercial non-Medicare ACO

- Contractually shared financial savings and risk
  - Targets for outpatient, inpatient, and pharmacy spending

- Members with Hill Physicians Group Primary Care Provider in Sacramento Region

Background: Sacramento Region ACO goals and expectations

Partners Stated Goals
Deliver cost savings
Grow membership
Maintain or improve quality of care
Sustainable model for expansion

CalPERS Expectations
Better coordinated care
Improved quality of care
More high value care and less low value care
Lower spending over time

Strategies
Better data exchange
Reduce clinical and resource variation
Manage utilization
Personalize care and disease management
Reduce pharmacy costs

Sample Initiatives
Push EHR to hospitals when scheduling admissions
Reduce ED use by using urgent care clinics
Coordinate discharge planning
Identify best physical therapy practices for chronic pain patients
Increase use of generics

CalPERS outcome study

- Sacramento Region
  - 40,000+ non-Medicare CalPERS members continuously enrolled in the HMO from 2008 to 2014
    - Always in the ACO cohort
    - Never in the ACO cohort
- Outcomes studied
  - Medical cost, utilization and clinical quality
  - Pharmacy cost and utilization
- Rigorous statistical methodology

Summary of Findings

The ACO cohort had:

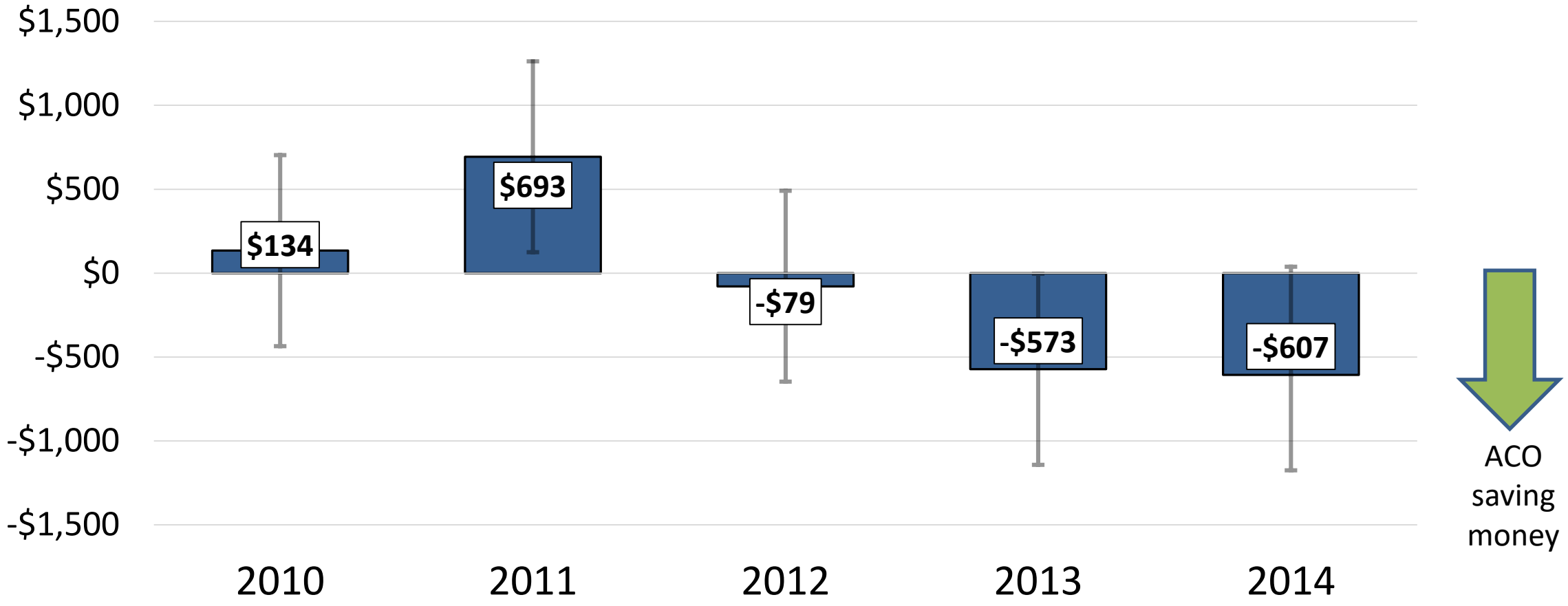
Lower overall spending in the last two years
~10% decrease in last year

Hints of improved quality of care

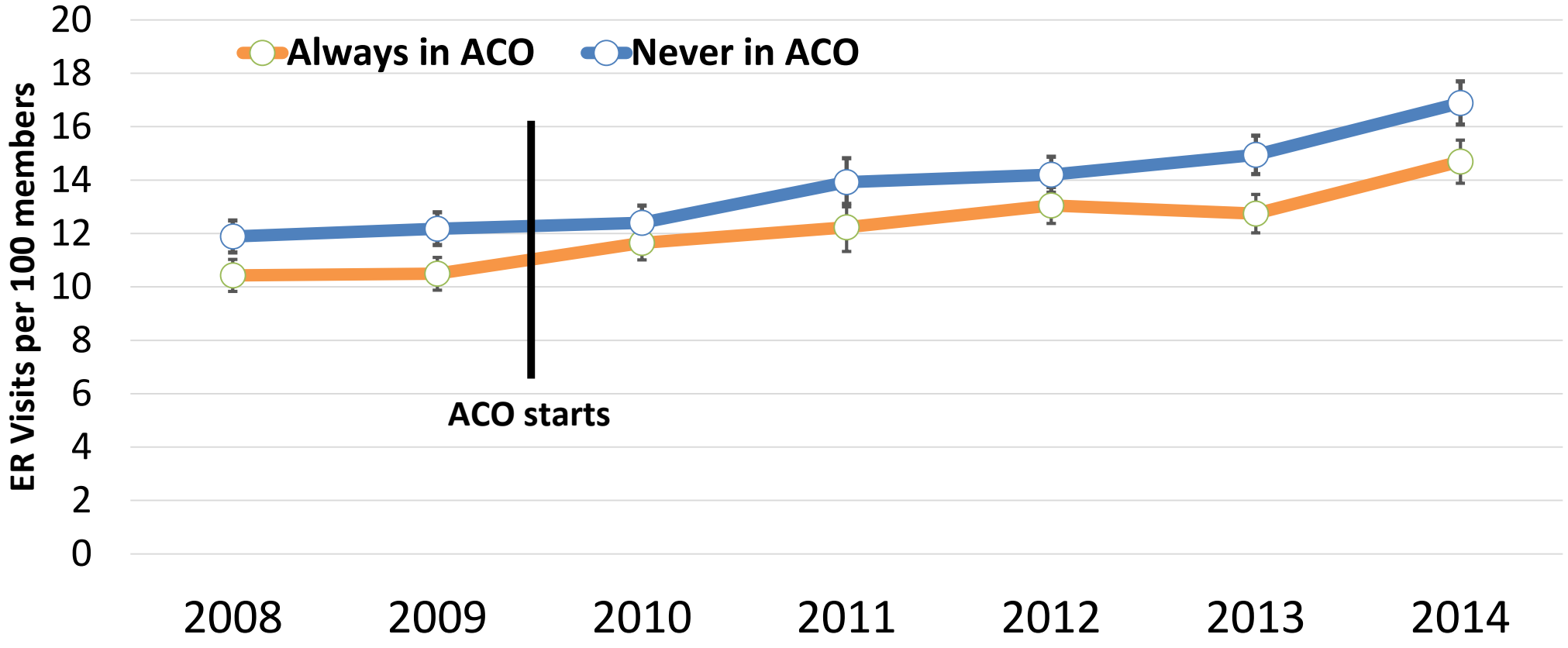
No differences in retail pharmacy spending or utilization

No differences in patient reported experience

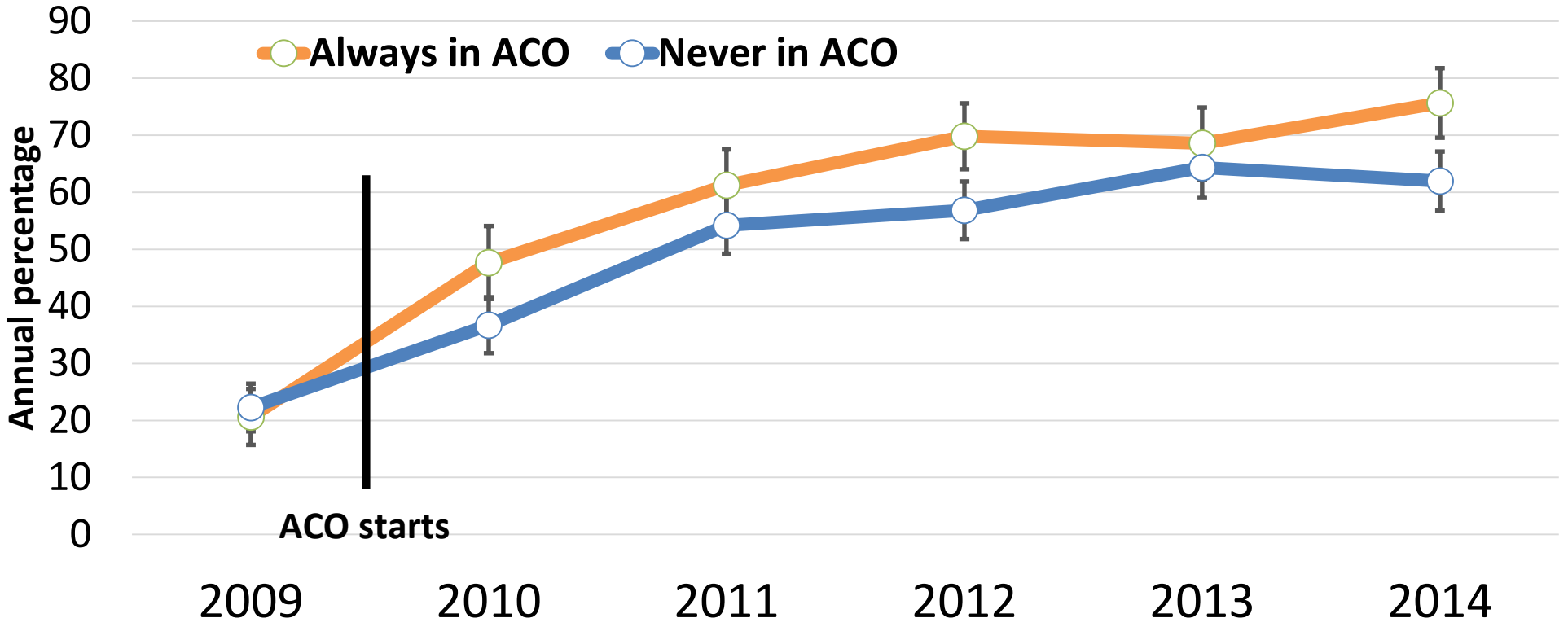
Annual total spending per member between Always in the ACO and Never in the ACO cohorts compared to 2009



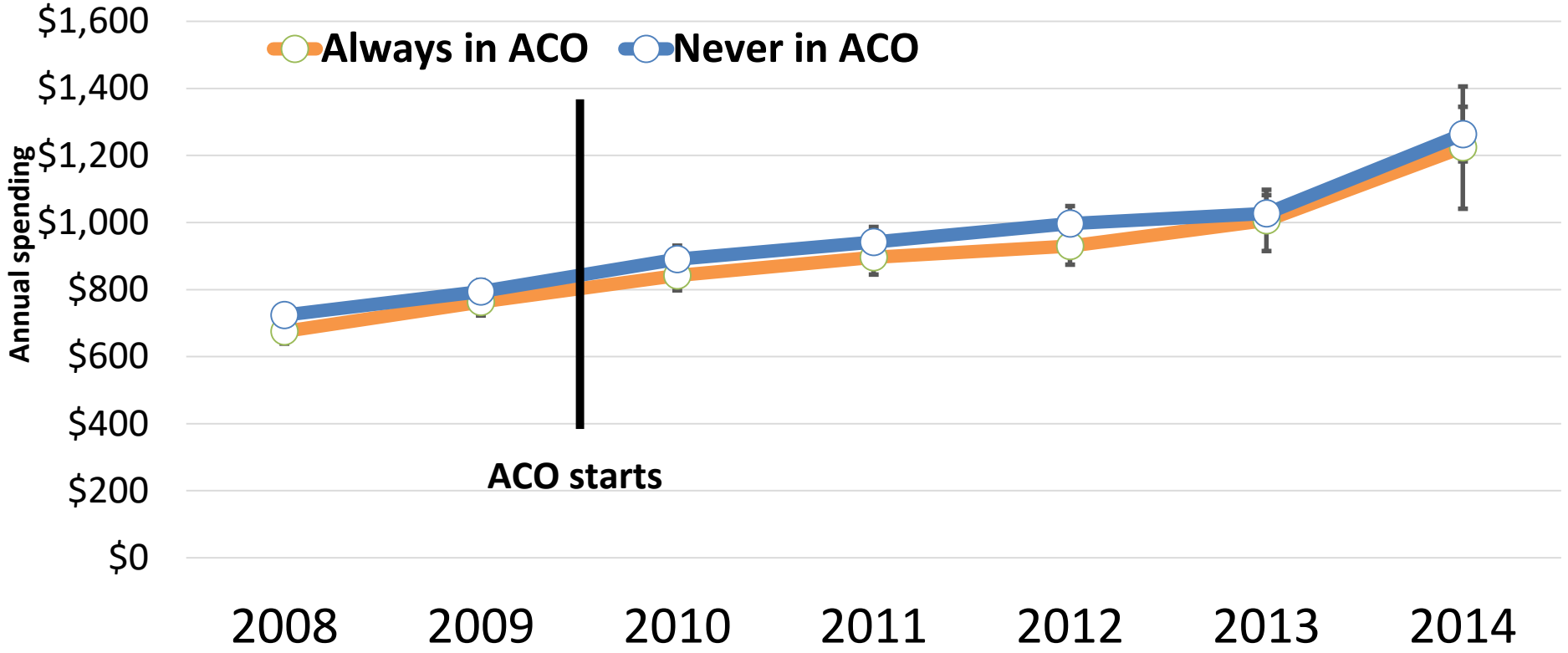
Yearly trend in ER visits per 100 members by ACO status



Yearly trend in annual percentage of complete immunizations for adolescents by ACO status



Yearly trend in annual spending for retail pharmacy by ACO status



CalPERS patient experience study

- CalPERS Accountable Care Survey
- CalPERS members in Blue Shield or Anthem
  - ~4000 members responded in early 2018
  - Patient reported experience
  - 40 questions in 10 care domains
- Only a few differences reported

Patient reported experience for 2017

	Members in ACO	Members not in ACO
It was easy to get appointments with specialists*	**80.6%**	73.2%
Provider's office followed up with results for blood test, x-ray or other tests*	**81.8%**	77.0%
Health care team talked with patient about specific things to do to prevent illness**	62.3%	62.8%
Health care team talked with patient about all the prescription medicines he/she was taking*	74.7%	74.8%

* Percent answering "Always" or "Usually"
** Percent answering "Yes"

Conclusions

- Lower spending in latter years
- Some better clinical quality measures
- Patient reported experience similar in most domains
- Lofty expectations
- Modest results with some promise

Discussion

- Time may be needed to see success
- Continual evolution
  - Larger financial incentives
  - More impactful strategies
- Carriers continually modify their ACOs
  - Change performance measures
  - Better benchmarking and cost targets

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What is the evidence on commercial payer ACO effects?

- CalPERS ACOs

- Alternative Quality Contract (BCBS of Massachusetts):
  - 5 year agreement—risk-adjusted global budget based on historical claims
  - Initially HMO enrollees, then expanded to PPO
  - 2-sided risk (total cost and 64 quality targets, with absolute performance thresholds)
  - BCBS provided data analytics to providers to spotlight and reduce variation in care

Source: Song et. al, Changes in Health Care Spending and Quality 4 Years into Global Payment, *NEJM*, 2014

What are the results of the Alternative Quality Contract?

- Slower medical spending
- Savings were concentrated in the outpatient setting and in procedures, imaging, and tests
- Incentive payments initially exceeded savings (2009-2011); by 2012, savings exceeded incentive payments in 2012
- Improvements in quality among AQC cohorts generally exceeded those seen elsewhere in New England and nationally

Source: Song et. al, Changes in Health Care Spending and Quality 4 Years into Global Payment, *NEJM*, 2014

What is the evidence on Medicare ACO effects?

- **Medicare Shared Savings Program (MSSP) has generated net savings to Medicare**
  - Reductions in spending grew with longer participation
    - Overall savings occurred modest
  - Some modest increases in hospitalizations
  - Early savings did not accrue in areas expected
  - Minimal effects on medication use and adherence

Challenges to ACO implementation persist

- **Leadership changes and shifts** disrupt program implementation
- **Lack of infrastructure** to support care changes
- **How to navigate relationships** in the context of a virtual system of care
- **Problems with real-time data sharing** across different HIT platforms
- **Care coordination issues** are cumbersome and time consuming

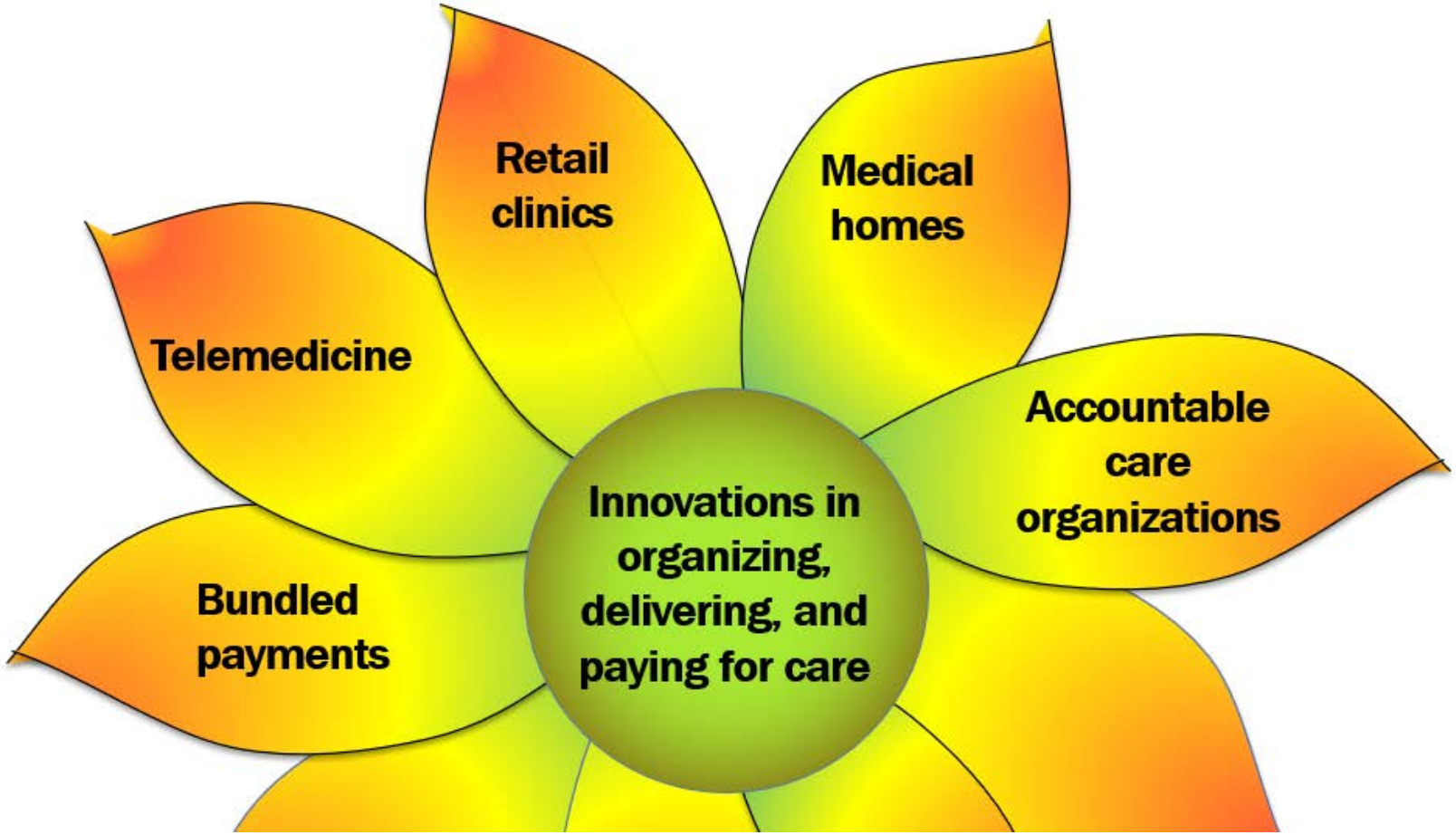
Issues to consider about ACOs and their potential success

- Need to **strengthen incentives**
- Need a substantial number of covered lives to **engage providers in making changes**
- Providers need resources to support **quality improvement**
- Achieving collaboration and alignment entails a **cultural shift**, which is not an easy process and takes time
- Moving to a **“value” orientation** requires a shift in perspective by providers
- Change is hard—especially if an organization’s leaders aren’t out in front leading and giving permission to experiment (and to fail)

Perhaps too soon to abandon the ACO concept…

- Continue to push for innovation in health care
- Work with payers and providers to strengthen and align incentives for value

The way forward: A thousand flowers blooming



Discussion

Did ACOs meet their original promise?

What is the future of ACOs in the healthcare marketplace?