“The country needs, and unless I mistake its temper, the country demands, bold, persistent experimentation. It is common sense to take a method and try it. If it fails, admit it frankly and try another. But above all, try something.”

Franklin D. Roosevelt, 1932
Payment Innovation in Health Reform Legislation

- Medical home: Expansion of current Medicare demonstration, new Medicare pilots, Medicaid initiatives
- ACO: Broad responsibility for quality and cost of patient care, rewards for quality, shared savings
- Bundled payments: Medicare pilots for hospital and post-acute care, Medicaid initiatives
- Medicare Advantage: Rates based on plan performance
- Center for Medicare and Medicaid Innovation

Center for Medicare and Medicaid Innovation

- Beginning in 2011, Center in CMS to test innovative payment and service delivery models to reduce program expenditures under Medicare, Medicaid, and CHIP while preserving or enhancing the quality of care; current demonstration authority expanded
- Models to be selected based on evidence that they address a defined population for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures
- Emphasis on care coordination, patient-centeredness
- Could increase spending initially, but over time must improve quality without increasing spending, reduce spending without reducing quality, or both
- Evaluation should include quality of care, including patient-level outcomes, and changes in spending; could consider cross-program impact
- Secretary could expand duration and scope if model reduces spending without reducing quality

Key Considerations for Successful Pilots

- Multi-payer involvement
- ‘Ground-up’ as well as ‘top-down’ development
- Array of potential models
- Flexibility in design and implementation
- Try vs. test/track but verify
- Establish infrastructure to support success
- Work with MedPAC, MACPAC/fed into IFAB deliberations

Improving the Process

- Transparency
- Site selection and approval
- Evaluation
- Translating pilots into policy
- Resource availability

Thank You!

Heather Drake,
Program Associate
Payment System Reform
hd@cmwf.org

For more information, please visit:
www.commonwealthfund.org

Ed Howard Comments
Toward Accountable Care
Where Policy Meets Practice: Lessons from the CMS Physician Group Practice Demo

Nicholas Walter, M.D.
Alliance for Health Reform Briefing
Washington, D.C.
May 13, 2015

ACO: Accountable Care Organization

- Current use evolved from discussion between MedPAC Commissioners & Elliott Fisher on November 8, 2006 in effort to define ways to control healthcare costs in an environment of regional variation in utilization and a largely unorganized & fragmented delivery system
- Further defined the following month in an article in Health Affairs [Health Affairs 26, no. 1 (2007): w44–w57 (published online 5 December 2006; 16.1377/hafft.26.1.w44)]
- Onslaught of ACO conferences, white papers, consultant Power Points, RWJF Pilot in New Jersey, etc.
- Effect of Physician Group Practice demonstration on discussions with CMS, MedPAC, Congress
- Culmination in Health Reform bill (both HR and Senate versions)
Program Environment: Billings Clinic

- Group Practice
  - 248 Physicians, 65 specialties, all employed
  - 39 (<0.5 FTE) specialists (Allergy & Vascular Surgery)
  - 8 clinic locations
  - 375 (205) bed tertiary hospital
  - Manager的支持6 CAHs
  - 1300 Connected Employees
  - 2nd largest employer in Montana

- Integrated Delivery System/ Medical Foundation
  - Board of Directors: community-based
  - Leadership Council (Internal board): physician-majority + senior administrators

10 Organizations

Physician Group Practices
- Great Falls, MT - Great Falls Clinic
- Manhattan, MT - ManMonte
- Missoula, MT - Missoula Clinic

Integrated Delivery Systems
- Springfield, IL - St. John's
- Sandia, PA - Geisinger
- Mt. Ida, OH - Waukesha Health
- St. Louis Park, MN - Park Nicollet
- Windham, ME - Norwalk Hospital

Academic & Network Org.
- Milwaukee, WI - Marquette University Hospital & Clinics
- Ann Arbor, MI - University of Michigan
- Boston, MA - Beth Israel Deaconess Medical Center

Mortons: 147,138 square miles and 922,002 people

PGF Demo Concepts

- Medicare Fee For Service continues as before
  - Business risk for the PGF
- If PGF is able to reduce the rate of growth of Medicare spending for the cohort under its care compared to a local comparison, CMS will share part of its savings with PGF
  - Savings is a function of expenditure control and health status changes
- Budget neutral project for CMS
- Meeting Financial Target = "Gate"
- Once "Open", PGF’s portion dependent on meeting Quality Measures

PGF Project Financial Model

Savings > 2%

<table>
<thead>
<tr>
<th></th>
<th>Quality</th>
<th>Efficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y1</td>
<td>80%</td>
<td>Performance Pay</td>
</tr>
<tr>
<td>Y2</td>
<td>20%</td>
<td></td>
</tr>
<tr>
<td>Y3-5</td>
<td>2%</td>
<td></td>
</tr>
</tbody>
</table>
CMS PGP Quality Measures

**Outpatient**

- **Year 1**: Diabetes
- **Year 2**: Year 1 plus HF and CAD
- **Year 3**: Year 2 plus Hypertension and colorectal and breast cancer screenings

PGP Quality Thresholds: Absolute or Relative Targets→ benchmarks or >10% improvement in gap (100% baseline)

Taken from the Doctor’s Office Quality measurement set in 1992. Thus some of the target measurements are not the current quantitative benchmarks.

---

**Common Basis for Strategies among the PGP Groups**

1. **Focus: High Cost Area**
   - Conditions of Medicare Expenditures
   - For Billings Clinic: (base year)
     - Inpatient: 45%
     - Hospital OP: 24%
     - Part B: 25%
     - SNF: 7%
     - Home Health: 3%
     - DME: 4%
   
   Reduce avoidable admissions, ER visits, etc.

2. **Focus: Chronic Care & Prevention**
   - High prevalence and high cost conditions
   - Provider based chronic care management
   - Care transitions
   - Prevention care

   Financial Savings are INPATIENT driven.
   Quality Measures are OUTPATIENT driven.

---

**Interactive Telephone System with Web-enabled Data Tracking**

- Utilizes daily monitoring system for patients via Interactive Voice data collection
- Patients call daily between 4 AM and Noon
- Data appears immediately on a web server
- HF “Care Coaches” (RN) call-out
  - Manage per HF protocols (diabetic)
  - Refer to HF Clinic, MDOHP or PNP
- Goal: coordinate care w/ “Tx Physician”
- Validated, proven system that manages by exception
- Allows for 1 RN to follow 2-300 patients

---

**Averted Admissions**

35-43% reduction in hospitalizations, or ~5/100/month enrolled in TA
Total: 795
Medicare: ~60%

---

**Advisory Board**

Moving the Dial and Gaining Interest
PGP Demonstration Displays Improving Improvements

<table>
<thead>
<tr>
<th>Year</th>
<th>Medicare Savings vs Non-Intervention Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>Year 2</td>
</tr>
<tr>
<td>Year 1</td>
<td>$5.4M</td>
</tr>
<tr>
<td>Year 3</td>
<td>$31.3M</td>
</tr>
</tbody>
</table>

Table for Medicare Savings vs Non-Intervention Group

The demonstration allows CMS to test new incentives in diverse clinical and administrative environments. Only in working with the groups to identify novel health care redesign and care management models developed for the demonstration that can be replicated and spread across the health care system.**

Centers for Medicare & Medicaid Services
April 2008
CMS PGP Objectives
- Encourage coordination of Part A & Part B
- Coordinate care for chronically ill and high-cost beneficiaries in an accountable care organization (ACO)
- Decrease the growth in Medicare spending over the next 3 years

Timeline
- Year 1: Calendar year 2004
- Performance Year 1: April 1, 2005 - March 31, 2006
- Performance Year 2: April 1, 2006 - March 31, 2007
- Performance Year 3: April 1, 2007 - March 31, 2008
- Performance Year 4: April 1, 2008 - March 31, 2009
- Performance Year 5: April 1, 2009 - March 31, 2010

Accountable Care Organizations

Key Features
- Local Accountability
- Shared Savings
- Performance Measurement

Key Design Components
- Organization well defined
- Scope of providers
- PCP essential
- Continuum of care
- Spending and quality thresholds to ensure success
- Distribution methodology for shared savings

Advisory Board

Shared Savings Bridges FFS, Capitalization

<table>
<thead>
<tr>
<th>FFS</th>
<th>Shared Savings</th>
<th>Capitalization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description: Possible paid on the basis of outcome of service provided to patient.</td>
<td>Group of providers jointly responsible for patient care and as a single budget to determine annual cap.</td>
<td>Global fee-for-service providers to manage all cost of care for given patient over a 12-month period or time.</td>
</tr>
<tr>
<td>Innovative Reimbursement</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Innovative Incentives</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Innovative Improvements</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Lean in Patient Care</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Rate of FFS</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Rate of Shared Savings</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Rate of Capitalization</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Degree of Coordination Between Providers</td>
<td>Low</td>
<td>Moderate</td>
</tr>
</tbody>
</table>

Scope of Accountability

- Single Service/Episode: Bundled Payment/ETG
- Disease Specific: P4P for outcome measures (PP, Medicare, etc.)
- Service Oriented: Medical Home payments
- Segment by Disease: CMS Chronic Care demo
- Total Population Care: Accountable Care Org

Medicare Payment Reform Framework: Organization and Payment Methods
Patient Protection and Affordable Care Act: ACO Definitions

- “Secretary (of HHS) shall establish”
  - significant degree of discretion in rule making
  - starts “not later than” January 2012
- Shared Savings Program
  - accountable for a population (>5,000 beneficiaries)
- Coordination of Medicare A&B
- Investment in infrastructure
- High quality and efficient delivery
- “groups of providers of services and suppliers meeting criteria” = ACO
  - Group practice arrangements
  - Networks of practices
  - JV between hospitals/providers
  - Hospitals/AD employed providers
  - Others?

Patient Protection and Affordable Care Act: ACO Requirements

- Accountable for quality cost and overall care for assigned beneficiaries
- Agree to ≥ 3 year period
- Form legal structure to receive and disperse payments
- PCP enough for population (± 10K)
- Specify the providers in ACO
- Leadership for clinical and administrative services
- Processes to ensure it
  - promotes EMR
  - reports quality, cost, & utilization measures
  - coordinates care (emphasizes technologies, care transitions)
  - assesses patient and provider experience
- Engagement in PQRI, e-Rx, EHR (‘meaningful use’), possibly higher standards than general Medicare providers

Patient Protection and Affordable Care Act: ACO Methodologies

- Assignment of FFS beneficiaries based on use of PC services
  - “appropriate method”; prospective vs. retrospective
  - Beneficiaries enrolled in A & B, excludes Part C (Medicare Advantage)
- FFS payments continue + potential for shared savings payments
- Benchmark to determine shared savings
  - prior 3 year average per capita expenditure for assigned ACO population
  - updated by national growth trend (absolute amount, not rate)
  - risk adjustment methodology required but not defined by statute
  - updated each performance period
- Savings occur if the average per capita expenditure is below a percentage of the benchmark that assures performance is not due to normal variation
  - 95% confidence interval, then population dependent
  - Quality requirements must be met
  - Secretary to determine percentage & maximum amount of net savings shared
- Other features
  - Monitoring of risk avoidance by ACO
  - Termination possible if ACO not meeting quality standards

Design Issues

- Attribution
- Beneficiary Participation
- Comparator Group
- Rapid Performance Feedback
- Risk Adjustment
- Infrastructure Investment Requirements
- Financial Design - 3% Threshold
- Shared Savings as a Longterm Design Feature

Other Thoughts

- Focus on high volume/high cost
- Continued need to refine FFS payment
- Eliminate incentives driving fragmented behavior
- Importance of some stick with the carrot
- Relationship between delivery system organization and payment policy can be nonlinear
- Importance of leadership/culture
- Importance of collaborative learning
- Rural healthcare providers can be players
Colligiality is the Key

“The key feature of the new integrated health care enterprise is not a balance of power, however, but the emergence of collegiality as the fundamental organizing principle. The essence of collegiality is tolerance and a sharing of common professional values. This trust and sharing of values is, in turn, the central precondition of the ability to share and successfully manage the economic risk of health costs.”

Jeff Goldsmith
Driving the Nitroglycerin Truck
Healthcare Forum Journal
March/April 1993

The past 50 years have been marked by advances in the science of medicine. The next 50 will be marked by improvements in the organization and teamwork of how healthcare is delivered.

Charles Mayo, M.D.
January 1913

Q&A Part 1

Q&A Part 2

Q&A Part 3

Q&A Part 4