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THE HEALTH INDUSTRY FORUM

ACO DEVELOPMENT: POLICY MEETS REALITY

CONFERENCE REPORT / MARCH 30, 2011 / WASHINGTON, D.C.

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The Health Industry Forum *is based at Brandeis University, chaired by Professor Stuart Altman, and directed by Robert Mechanic. The Forum brings together public policy experts and senior executives from leading healthcare organizations to address challenging health policy issues. The Forum conducts independent, objective policy analysis and provides neutral venues where stakeholders work together to develop practical, actionable strategies to improve the quality and value of the US healthcare system.*

Conference presentations and other background materials are available at www.healthforum.brandeis.edu.

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Key Themes

Overview

The general consensus of Forum participants is that accountable care organizations (ACOs) have the potential to bring about significant changes in healthcare delivery. While organizations were still anticipating new Medicare rules at the time of the meeting, and developing strategies for responding, most believe that the core concepts of ACOs – accepting responsibility for the cost and quality of care delivered to defined patient populations – represents the future of healthcare. To do so effectively, providers must organize in a more integrated manner and enhance coordination of care through the intelligent use of information technology.

As new initiatives are developed, policymakers need to better determine the best way to structure ACO programs, including how to assign patients to an ACO, communicate with patients about their participation in coordinated care, and encourage collaboration between payers and providers in other ACO-like arrangements. These decisions can have substantial impact on local hospital, physician, and insurance markets. If new payment and delivery reforms are unable to control growth in health spending, more drastic actions, like rate regulation will become increasingly possible.

Context

On March 30, 2011, the Health Industry Forum brought together a diverse group of stakeholders to examine the potential implications of Medicare's new shared savings program on the development of accountable care organizations. The meeting was planned in anticipation of the proposed regulations, but their release was delayed until March 31st. Subsequently, participants focused on lessons from Medicare's physician group practice demonstration and development of commercial ACO programs.

Key Themes

- **The industry's growing emphasis on ACOs is causing providers to reassess how they deliver care.**

  The goals of accountable care organizations (ACOs) include increasing the capacity and effectiveness of patient-centric primary care, effectively coordinating medical services for high-risk patients, and improving population health in a cost-efficient manner. As CMS begins to implement its new shared savings program, many providers believe that establishment of new programs for compensating ACOs could be an essential step in the transformation of healthcare. While future payment models may evolve toward bundled payments or capitation, the CMS ACO pilot is intended to be an important first step towards giving health care systems stronger incentives for managing expenditures and improving quality. Thus, providers believe that they will need to operate more efficiently, with greater coordination and integration. As one provider said, "Regardless of health reform, regardless of the ACO regulations, we are leaving the current model and we will not return."

  There are no one-size-fits-all ACO models. ACOs will differ across geographies and health systems. Not all providers are interested in becoming ACOs, but they will nevertheless face increasing pressure to embrace the need for improved coordination of care, quality and safety, and use of information technology to manage patient care more effectively.

- **Demonstrations of ACO-like delivery systems have shown some positive results, as well as hurdles to overcome.**

  Lessons from Medicare's Physician Group Practice (PGP) Demonstration Project have been used to inform the development of Medicare's shared savings program. The PGP began in 2005 and enrolled ten multispecialty group practices in a shared savings program where groups would receive additional payments if they held spending below annual budget targets while achieving defined quality thresholds. While all of the groups achieved the programs quality goals only five received shared savings payments. A review of this program suggests several important changes that would make the program more effective and more viable for providers.

  In the PGP, patients were assigned retrospectively to health systems based on the preponderance of patient charges. The systems were not informed about which patients they were responsible for until 6 months after the year ended. This was most problematic at the start of the demonstration. In the new model patients will likely be assigned based on primary care visits, allowing the groups to estimate who is in their assigned population more effectively. Also in PGP, groups were eligible to share 80% of the savings but only if they achieved a 2% aggregate savings. Even then, CMS retained the first 2% of savings. As a result, a number of groups received no payments even though they saved significant amounts for the government. PGP participants identified a number of other technical issues that they believed should be changed for the ACO program.

- **Medicare ACOs can substantially affect local hospital, physician, and insurance markets.**

  With a mandate for reducing costs and strengthening primary care, many ACOs are likely to try and trim expensive hospital services. Hospitals and hospital-based ACOs may respond by acquiring or trying to align with physician practices, both to better coordinate care transitions and to ensure a consistent stream of hospital referrals. Some healthcare experts see these acquisitions as necessary to provide greater economies of scale, but others are concerned about consolidation of market power and mini-monopolies in local markets. The Federal Trade Commission will watch this closely in order to prevent excessive consolidation.

- **It is not clear whether shared savings provide ACOs with sufficient incentive to reduce health care spending. If not, rate regulation is a possibility.**

  While many in the health care community are optimistic about the potential for ACOs to serve as catalysts in transforming care delivery, others are concerned that ACOs might not prove effective at controlling healthcare costs. If ACOs and other health reform policies are unsuccessful in stemming the growth in costs, federal and state governments may consider more radical cost-control options, such as all-payer rate regulation or global budgets. Most forum participants would prefer private market solutions and are concerned about the future prospects for rate regulation.

Introduction: Can the U.S. Moderate Health Spending Through Delivery System Reform?

Presenter: **Stuart Altman, Ph.D.**, *Professor of National Health Policy, Brandeis University*

Overview

We know that delivery system reform is proceeding as providers prepare to create accountable care organizations (ACOs). But no one yet knows what impact ACOs will have in controlling (or exacerbating) healthcare spending. While to date the United States has lacked the political will to control health costs, continuing to do more of the same is unsustainable. In the future, policy changes to control costs will be essential, and could include drastic actions such as some form of rate regulation.

Context

Stuart Altman set the stage for discussing ACOs by focusing on healthcare spending and discussing whether this delivery system change will be able to control spending. He considered potential implications if ACOs cannot control spending.

Key Themes

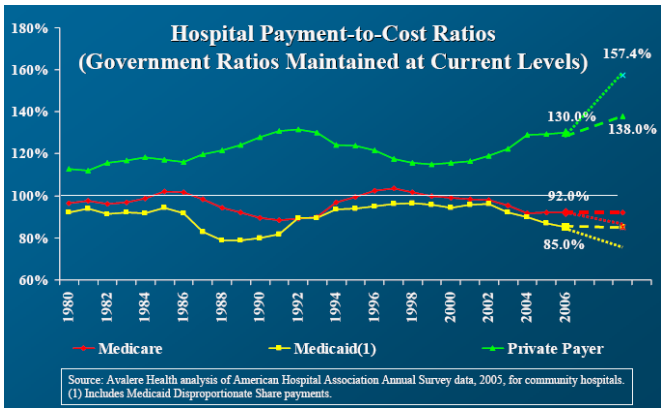
- **To date the United States has lacked the political will to control healthcare costs.**

  As healthcare spending in the United States continues to increase, people ask whether it is possible to control it. Of course it is possible, as other countries have shown. But it takes political will, which has been lacking in the United States.

  The reason that political will has been lacking is that those who stand to lose if healthcare spending were to be controlled convince policymakers that controlling costs won't work because it will reduce access to care, lead to lower-quality care, and reduce jobs in communities.

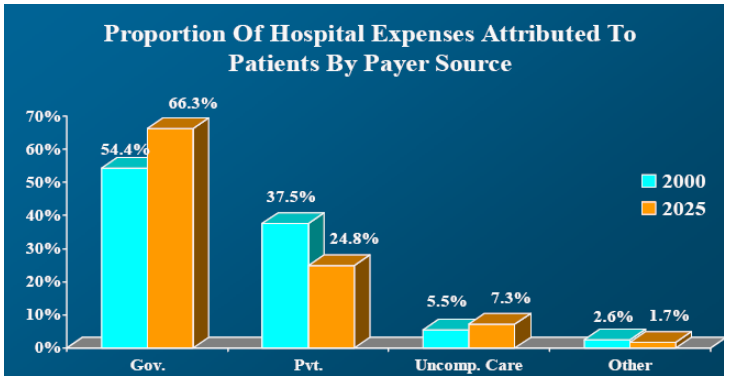
- **The future can't be more of the same, as the current trajectory of healthcare spending is unsustainable.**

  Continuing to do more of the same is not a viable alternative. As the following graphic shows, on average, hospitals lose money on Medicare and Medicaid patients. The reality is that hospitals and physician groups have been able to survive by extracting enough from private payers to keep them afloat.



But losing money on government-pay patients and making it up through higher payment-to-cost ratios on private-pay patients is unsustainable. The chart below shows that even in the absence of health reform, demographics and growth in the low-income population is driving an increase in the proportion of hospital expenses paid by the government and a decrease in the proportion paid by private payers.

Overall, more than 65% of hospital expenses are expected to be paid by the government and many hospitals will receive 80% of their revenue from government programs. With a higher proportion of patients in government programs and a lower proportion in private payers, it is unlikely that hospitals will be able to charge insurance companies enough of a premium to make up for low government payments. Something must change.



- **ACOs are designed to avoid the problems of the HMO debacle of the 1990s, but it not clear if this approach will control (or increase) healthcare spending.**

  There remains much uncertainty about ACOs. (The draft ACO regulations were published on March 31, 2011, just one day after this forum.) However, the expectation is that ACO rules will seek to avoid two of the main problems associated with HMOs:

  1. **Providers will not be required to assume financial risk.** The experience of the 1990s showed that providers were not equipped to take risk as they lacked the data systems and risk-management capabilities. Instead, ACOs will be a "shared savings" system.
  2. **Patients will not be locked into a delivery system they don't trust.** HMOs restricted consumer choice; ACOs will largely give patients the ability to do what they want. (If patients have no restrictions and can largely do what they want, can we really control costs?)

  Optimists believe ACOs and like organizations will be able to overcome the many hurdles and provide higher-quality care while controlling costs. But many experts are skeptical, believing that the ACO approach would lead to higher costs. Mini-monopolies have the potential to increase the rates paid by private payers. Also, allowing patients to do what they want without restrictions or penalties could make it hard to control costs.

- **If ACOs and other attempts to control spending don't work, government-imposed rate regulation is possible.**

  The long-term bogeyman is the country's deficit and the projected growth in entitlement programs. In 2010, Social Security, Medicare, and Medicaid represented 10% of GDP. Looking ahead to 2030, they are projected to represent 16% of GDP, and 20% in 2070. Medicare is the primary source of growth.

  Controlling the growth of Medicare spending will be a major source of debate and many ideas will be surfaced. For example, the Deficit Reduction Commission recommended establishing a Medicare voucher system with limited growth in government payments. This would impose a structural limit on spending.

It is also possible to envision government rate-setting regulations to control costs. The first signs of this can be seen in Massachusetts, which is seen as a leader in healthcare reform.

> *"If we do nothing and do not transform the delivery system through a new payment system, the money issue will continue to dominate . . . and some form of rate regulation may be inevitable."*
> —Stuart Altman

The governor of Massachusetts has proposed powerful cost-containment regulations which, among their many provisions, would give the Department of Insurance the power to regulate rate increases and approve provider contracts. This type of regulation is symptomatic of what is likely to be proposed in many parts of the country.

Federal ACO Rules: Implications for Provider Systems

Presenter: **Thomas Graf, M.D.**, *Chairman, Community Practice, Geisinger Health System*
Discussants: **Michael Hillman, M.D.**, *Chief Medical and Quality Officer, Summa Health System*
Ira N. Hollander, M.D., *President, North Texas Specialty Physicians (NTSP)*

Overview

The experience of provider organizations in managing patients within Medicare demonstrations and capitated contracts illustrates how providers are thinking about the key issues they will face in becoming an ACO. Leading provider systems recognize the change in priorities as they adapt their systems and processes to deliver greater value, operate more efficiently, and remove waste. This requires breaking silos, using technology, coordinating care, and improving physician efficiency.

Context

Dr. Graf provided an overview of the Medicare Physician Group Practice Demonstration Project (PGP), described changes that will be made for the new PGP Transitions program, and discussed how the PGP methods may apply to ACOs. Representatives from two large delivery systems shared how their organizations are making the transition to delivering accountable care.

Key Takeaways (Graf)

- **The PGP demonstrated the feasibility of ACOs but lessons from the program should be used to design improved ACO policies.**

  The first Medicare Physician Group Practice Demonstration Project ran for five years, from April 1, 2005 through March 30, 2010. The purpose of this demonstration was to see if large, multispecialty group practices deliver higher-quality care at lower cost than surrounding physicians and hospitals. Ten organizations participated in this project, including the Geisinger Health System.

  Dr. Graf called PGP a good first experiment with mixed results. He noted issues with the design and methodologies, including:

  —*Quality measurement*. PGP's design drove participants to achieve the project's quality targets, not necessarily to achieve the best possible quality. Dr. Graf said, "We studied for the test." As a result, groups that were already doing a good job on quality did even better. In years two, three, and four Geisinger achieved 100% of the PGP's quality metrics.

  —*The comparison group*. In PGP, cost savings were based on comparing patients that were attributed to the demonstration project with other patients in the same local geography. Because it was not always possible to know which patients were counted in the PGP group, the groups were also treating some of the "control group" patients, making it harder to show a comparative advantage.

  —*The "shared savings" formula.* If a group treated their assigned population for less than the spending benchmarks, the first 2% of savings went to CMS. The group was allowed to keep 80% of any additional savings. The 2% savings corridor was a threshold to show that the savings were real, rather than random variations in cost, but was a large financial hurdle for the groups. In the first four years of the demonstration project, six of the 10 PGP participants earned some shared savings. Geisinger received $1.95 million in year three and $1.8 million in year four. (Year five results are not yet final.)

  —*Risk governor and methodology*. Treating a sicker population is naturally more expensive. But CMS was concerned that PGP groups would improve the coding of complications and comorbidities to make their population seem sicker in order to generate higher spending thresholds, so the demonstration set a maximum annual change in each group's risk score. Geisinger retooled one of their community hospitals into a tertiary care center during the demonstration; however, the "risk governor" prevented them from getting credit for the riskier patients they were treating.

- **Several important changes in the program design were made for PGP2 that have relevance for ACOs.**

  CMS has created a second Physician Group Practice Demonstration (PGP2) that began on January 1, 2011. The 10 group practices from the first project are eligible to participate in PGP2. Among the important changes in PGP2 are:

  —*Timing*. PGP1 took place over five years. PGP was initially planned as a three-year demonstration but was revised to be a two-year demonstration.

  —*Comparison group*. Instead of a local control population, PGP2 will compare the results of participating groups to national averages to determine the cost thresholds and amount of shared savings.

  —*Calculation of shared savings*. The 2% withhold from shared savings from PGP1 has been eliminated. In PGP2, once physician groups prove that their savings are statistically significant, the physician group receives 50% of the shared savings from the first dollar saved.

  —*Accrued loss*. Rather than resetting the benchmarks each year, losses in early years are carried forward and offset future savings. For example, if a group practice spends $1 million more than predicted in year one but then saves $4 million in year two, the initial loss reduces the savings in year two to $3 million (of which the practice gets 50%, or $1.5 million).

  —*Withhold*. CMS will withhold 25% of a group's earned savings during the first year of PGP 2 in case the organization does not save money the next year. This could be a significant amount of money and create up to an 18-month delay in receiving the funds. If this rule is applied to ACOs, it may be a substantial problem, especially for small practices.

  —*Savings cap*. Savings shared with a physician group are capped at 5% of total Medicare spending.

  —*Risk adjustment*. Risk adjustment has been modified to lower the impact of acute events. But this doesn't impact a group's risk score until the following year.

—*Data flows*. Data flows between providers and CMS haven't improved much over the past 20 years. Improving data flows is a goal in PGP2, with quarterly data files and monthly feeds of hospital, emergency room, and rehabilitation census.

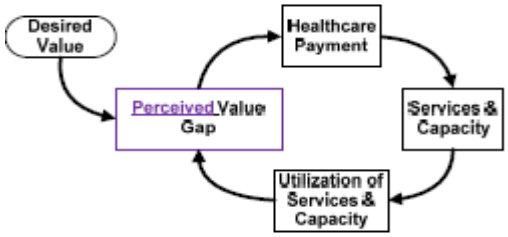
—*Quality reporting bonus*. All of the savings in PGP2 will be quality gated. Participating groups can receive an additional 5% of shared savings for reporting data on bundled metrics and can receive another 5% for reporting data on patient experience. So, participating practices can receive up to 60% of shared savings. Dr. Graf does not expect these additional bonuses to be part of the ACO rules.

Key Takeaways (Hillman)

- **ACOs may be focused on symptomatic solutions, not real value.**

Summa Health System in northeastern Ohio consists of seven hospitals, a 240-member physician group, a large physician network, and SummaCare, a health plan with 155,000 members. Like other health systems, Summa has traditionally delivered care in silos. But Summa's focus is to take a system perspective in reorganizing its care system. The goal is to deliver patient-centered care by breaking down the silos.

Using the following diagram, Dr. Hillman explained that the healthcare payment system influences the services and capacity supplied. This, in turn, influences the amount of utilization, which influences the perceived value gap. In a fee-for-service environment, utilization and service capacity increase continually. In the managed care system of the 1990s, utilization and service capacity decreased. With Medicare's proposed shared savings model which includes performance measures, many people believe that services, capacity, and utilization all will decrease.



Dr. Hillman believes that population and personal health needs (not payment) should be what drives the relation-ship between services, capacity, and utilization. These need to be reframed in terms of prevention, engagement, and care-cycle activities, which produce measurable outcomes relative to cost to continually improved value across the care continuum. Clinician-led ACOs, especially those that truly partner with provider-based health plans, are the best opportunity to reframe the system and its value gap in terms of population health needs.

However, he is concerned that value-based purchasing in combination with shared savings programs as put forth by some payers (including CMS) are providing symptomatic solutions that they call ACOs; but will not ultimately meet the potential for a true ACO. While these efforts can help as part of a transition toward care
redesign, we must get to the work of defining value based on population health needs, and develop a payment system that supports the continual reduction in the outcomes relative to cost. The focus on "performance" and shared savings could distract providers from delivering real value.

- **Summa is focused on fundamentally changing its processes and care system to address the value gap.**

A key part of Summa's strategy for delivering patient-centered care is its ACO collaborative, which began operation on January 1, 2011. This is a clinician-led partnership of six physician groups, seven hospitals, and SummaCare that will initially cover 10,000 Medicare Advantage members currently seeing a participating primary care physician.

The focus of the ACO, and of other activities within Summa, is addressing the perceived value gap in healthcare. While Summa is currently a hospital-centric system, they recognize the need to shift management services like care coordination, utilization management, and disease management to physicians. Dr. Hillman believes providers can offer these capabilities more efficiently and with better integration than payers. Strong administration and infrastructure will help remove barriers so that physicians can practice more efficiently.

> *"Regardless of health reform, regardless of the CMS ACO regs, we are leaving where we are now and will not return."*
> — Michael Hillman

Summa's next steps are to expand its ACO, continue improving integration, and add capabilities in areas such as risk management and measurement. Using Lean, Six Sigma, and other management tools, Summa will seek to reduce cost and potentially rationalize services. Summa may participate in a CMS demonstration, if doing so doesn't distract the organization from its focus on value and patient-centered care.

Key Takeaways (Hollander)

- **Based on its business model, NTSP has little interest in shared-savings ACO models compared to capitation and other risk-based contracts.**

North Texas Specialty Physicians is a physician-driven independent practice association (IPA) in Fort Worth, Texas, with more than 600 doctors. NTSP has participated in capitation contracts since 1997 and currently has 30,000 capitated lives in a Medicare Advantage HMO and PPO.

Because its physicians are highly independent, NTSP's focus has been to provide them with information at the point of care to help them make better decisions. NTSP has invested in electronic medical records, created a robust health information exchange, and created a quality module with multiple features including point of care decision support, population reporting, a patient registry, and physician utilization reports. They work closely with hospital partners with some shared governance projects, but have no intention of forming an integrated delivery system.

Because of NTSP's model and history managing capitated patients, it is hard for NTSP to envision a shared savings model being successful. NTSP's physicians are cash flow driven and the lag in receiving shared savings won't work for this IPA.

Instead, NTSP wants to expand its participation in risk-based contracts, whether commercial projects or pilots sponsored by the Center for Medicare and Medicaid Innovation. This would fit best with NTSP's structure, culture, and capabilities.

Participant Discussion

- **Marshfield Clinic.** Marshfield Clinical, a group practice in Wisconsin with about 750 physicians, was one participant in PGP Demonstration. Marshfield consistently achieved excellent quality and cost-savings results, earning shared savings of about $40 million in the PGP's first four years. When asked what lessons could be drawn from this case study, representatives and participants commented that Marshfield had started early with information technology and leveraged its electronic health record toward protocols and nurse-practitioner led clinics. Marshfield used its information technology in combination with population health principles to develop a care management coordination and communication call center that made it easier for both the patients and providers to do the right things for the health of the patients. If integrated healthcare delivery processes can be redesigned to make it easier for providers to deliver "effective care", behavior can change even in the current FFS system.
- **Medical home.** In Geisinger's experience, a key driver of shared savings was deployment of a medical home model. This resulted in better day-to-day management of patients that helped the group to find opportunities for savings in inpatient, nursing home, radiology, and pharmacy costs.
- **Hospital capacity.** Dr. Graf admitted that Geisinger was fortunate to be able to find new patients to fill empty inpatient beds created by reducing avoidable admissions, but believes this capacity will be temporary. He attributes much of the decrease in hospital utilization to reductions in readmissions for chronic conditions like CHF and COPD which are unprofitable cases anyway.
- **Local vs. national comparison.** Some forum participants disagreed with the idea of basing a group's shared savings on a comparison to national benchmarks. As one participant said, "Healthcare is local." A provider's local rate is what they can influence and what should be used for comparison. Some viewed a regional benchmark as more appropriate. If the ACO rules use a national benchmark as the basis for shared savings, providers in some areas will quickly create ACOs because their costs are growing slower and they can show savings versus the national trends—not through specific efforts to lower costs, but just because of their particular geographic advantage.
- **Size requirements.** If ACO policies are similar to those of the PGP transitions program then size will be an important factor regarding who signs up. Because groups must first show a statistically significant cost savings, Dr. Graf suggested that an ACO will need to have at least 20,000 people in order to succeed. This essentially prices small groups out of the program.
- **Aligning with hospitals.** In some geographies, ACOs could reduce demand for hospital services, leading to a reduction in the number of beds that are needed. Physician groups and hospitals don't need to be jointly owned, but they will have to be closely aligned to manage the reduction in utilization in a mutually beneficial way. Otherwise, some hospitals will suffer.
- **Reducing waste.** Payers are trying to reduce healthcare reimbursement, which is forcing providers to deliver care more efficiently with less waste. Dr. Hollander believes that putting primary care physicians on a flat capitation and putting specialty physicians on a budget—and then letting the physicians decide the most efficient way to care for patients—will take a great deal of waste out of the system.

How Will ACO Beneficiary Assignment Work and Can It Work?

Moderator: **Christopher Tompkins, Ph.D.**, *Associate Professor and Director, Institute on Healthcare Systems, Brandeis University*
Discussants: **Barbara Walters, M.D.**, *Senior Medical Director, Dartmouth-Hitchcock Medical Center*
Matthew Day, F.S.A., *Senior Director, Provider Financial Management, Blue Cross Blue Shield of Massachusetts*
Joseph Baker, *President, Medicare Rights Center*

Overview

Lessons learned with beneficiary assignment in the PGP Demonstration Project helped refine the process and criteria for attributing patients to practices in subsequent demonstrations and now the ACO pilot. The experience of Dartmouth-Hitchcock and Blue Cross Blue Shield of Massachusetts shows that attribution can work to identify patients and compensate groups in ACOs and other risk-based contracts.

Joseph Baker stressed that assigning Medicare patients to ACOs must be transparent and that patients not be locked in; they must have choice. He believes that when patients understand the benefits of ACOs, most will want to participate.

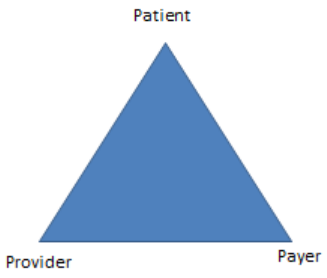
Context

For ACOs to be "accountable" for the health of a patient population, they need to know which enrollees are included in that population. This session discussed different ways in which payers could attribute patients to providers, and how these algorithms might affect referral patterns and consumer choice. Christopher Tompkins began the discussion by describing the motivations for the key stakeholders in healthcare and the thinking behind the attribution model. Representatives from one major provider and one major payer explained how they are working through different types of patient attribution in their systems, and Joseph Baker, a consumer advocate, provided his perspective about attribution and Medicare ACOs.

Key Takeaways (Tompkins)

- **The needs of each stakeholder need to be understood and managed properly, or else the system doesn't work.**

  In healthcare economics and policy, a "relationship triangle" shows the three key stakeholders: patients, providers, and payers. It is important to understand what each wants:



  - —*Payers* want a budget they can live with that is consistent with their expectations of costs and ultimately lowering the rate of increase. They want an incentive structure so that participants will play the game fairly, and they want the other players to stay within the budget.
  - —*Providers* want proper responsibility, autonomy, and credit.
  - —*Patients* want to be active participants in their healthcare and don't want to be exploited.

  At times, different parties form alliances, to the detriment of the other party. For example:

  - —*Fee-for-service*. This represented an alliance between providers and patients, which forced payers to act defensively.
  - —*Managed care*. This represented an alliance between payers and providers. Payers exerted influence on providers and shifted risk. The explicit control by payers caused a consumer backlash.
  - —*Health savings accounts (HSA) and disease management*. These represent a type of alliance between payers and patients that discourages use of providers (HSAs) or takes providers out of the loop (disease management).

  This triangle will not go away; it needs to be managed because medicine is a team sport. Attribution is a way to balance the triangle. The original intent of the Physician Group Practice Demonstration Project (PGP) was to ensure that Medicare fee-for-service would not be a barrier to providers developing effective responses to new managed care payment systems.

Key Takeaways (Walters)

Barbara Walters shared Dartmouth-Hitchcock's perspective on attribution. Dartmouth-Hitchcock is a multispecialty group in New Hampshire and Vermont and was one of 10 participants in the PGP. Dartmouth-Hitchcock has also entered into ACO-type agreements with three private payers, each of which has its own assignment methodology.

- **Lessons learned from the original PGP demonstration drove CMS and participating groups to develop a better beneficiary assignment algorithm for PGP2 (and the ACO program).**

  In PGP, assignment was done retrospectively; beneficiaries were assigned to group practice based on the preponderance of their outpatient evaluation and management (E&M) billed claims for the year. In other words, the group practice was responsible for the total cost and quality of care for a beneficiary if that patient visited them more than any other provider for their non-procedural primary care, ambulatory, and chronic care needs.

  But patient assignment couldn't be completed until Medicare processed all claims from a given year. Thus, the practice didn't know who was officially assigned to their group until 15-18 months after care was provided. During the treatment period, providers could only guess as to which patients would be assigned to them.

  Because of this uncertainty, Dartmouth-Hitchcock tested a series of models to predict which patients were "theirs," They investigated: the number of assigned patients out of the potential total number of patients treated; the percent of E&M-allowed charges provided by a group; the characteristics and clinical

competencies of a group; and "stayers," which were patients who stayed with a practice over a long (five-year) period. Dartmouth-Hitchcock found that if a patient visited a system provider at least three times, they were almost definitely going to stay with them for the entire year.

For PGP2, CMS asked participating groups to vote on an improved algorithm for beneficiary attribution. Options included:

- *Primary care E&M visits or all ambulatory care E&M visits:* Should patients be assigned to groups based on where they get their primary care or where they get the most (non-hospital) care overall? While tying patients to primary care providers links the PCP and ACO concepts to the medical home model, it also restricts whether academic health centers and other specialty providers can participate.
- *Site of service*: Should PCP visits be restricted to management visits only within a physician's office visit? Or should it also include evaluation services conducted in skilled nursing facilities, home health visits, and through hospice services? For Medicare patients, these alternative sites of care are frequently used and can be identified through expanded physician billing codes.
- *Chronic care providers:* Many patients see cardiologists, nephrologists, or endocrinologists for their chronic care needs, rather than seeing a traditional primary care provider (internal medicine, family practice, general practice, or geriatrics). Should these visits count in the assignment algorithm when there is no evidence of a PCP visit?

Between these alternatives, seven unique combinations of options were put to a vote. Based on their experience with PGP1, Dartmouth-Hitchcock modeled all of the options. They concluded that the overall numbers between choices were pretty stable and were confident they could identify over 90% of patients that would have been assigned to them.

> *"[In any of these algorithms], once you know your docs, you likely know your patients."*
> — Barbara Walters

In the end, nine of the ten participating groups in PGP2 (including Dartmouth-Hitchcock) voted for a method that based assignment on a plurality of primary care E&M visits; expanded codes to include PCP visits outside a physician's office, plus provisions for when patients did not have any primary care visits. Only the academic health center, University of Michigan, voted for an alternative option.

Dartmouth-Hitchcock has leveraged this experience to develop ACO-like contracts with private payers. Dr. Walters commented on these contracts and their attribution method:

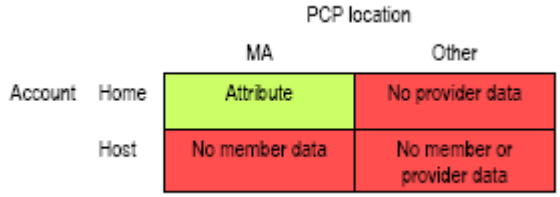
- *CIGNA* uses a primary care attribution model similar to the one used in the PGP demo, but allocated patients to PCP each quarter. CIGNA is including about 20,000 self-funded patients.
- *WellPoint/Anthem* is not comfortable including self-funded patients and only includes HMO and PPO patients.
- *Harvard Pilgrim* has similar criteria to CIGNA, but doesn't include self-funded patients.

Key Takeaways (Day)

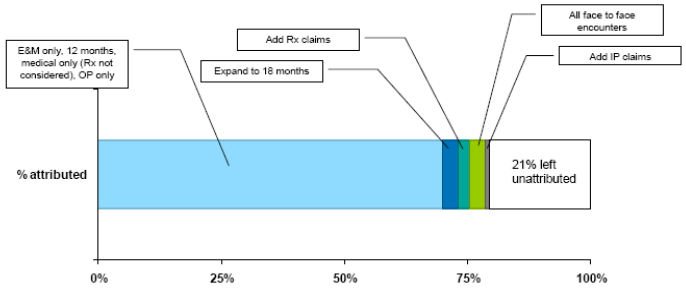
Matthew Day described Blue Cross Blue Shield of Massachusetts' (BCBSMA) experience with modeling patient attribution for some of its Alternative Quality Contract (AQC) providers. The AQC is a modified global payment contract that specifically ties reimbursement to quality goals. Like the PGP, participating provider groups must manage a population's health within preset quality and cost standards. Unlike the PGP, AQC groups are responsible for financial losses if they should go above their cost threshold. To date, BCBSMA has only used the AQC in its HMO product where the benefit design requires enrollees to select a primary care provider (PCP) and obtain authorization from that PCP for specialty referrals. However, Blue Cross is considering expansion of the AQC into PPO products that do not have explicit attribution.

- **BCBSMA is able to accurately assign 79% of its attributable members.**

  Not every BCBSMA member can be attributed via the plan's internal claims system. As the following chart shows, if an employer-account has its headquarters outside of Massachusetts or if a member's PCP is outside of the state, BSBSMA does not have the data necessary to attribute a specific beneficiary to a specific primary care physician.



  For the available population of PPO members, BCBSMA has been able to use claims data to attribute 79% of members to a network PCP. The table below shows that approximately 70% of members can be attributed based only on primary care and outpatient medical E&M visits over the past 12 months. An additional 9% of members are attributed when taking into account 18 months of data, prescription claims, all face-to-face encounters, and IP claims. Mr. Day postulated that most of the 21% left unattributed had no interaction with the healthcare system in the last 18 months or visited an out-of-system PCP.



  BCBSMA validated its attribution algorithm with a large physician organization as a pilot test. Of those that could be attributed, the plan successfully assigned 70% of their members to their exact PCP; another 22% were successfully connected to the practice site or physician organization. The physician group was comfortable enough with the 92% match rate to continue discussions about taking risk for an attributed population.

Key Takeaways (Baker)

Joe Baker is the president of Medicare Rights Center, a national non-profit consumer service organization that works to ensure access to affordable healthcare for older adults and people with disabilities. Mr. Baker provided the perspective of a consumer rights advocate.

- **Consumers need to be informed about attribution policies in advance.**

  In Mr. Baker's view, as ACOs are rolled out, the keys to success are transparency and voluntary participation. Consumers must know in advance about participation, know about the structure of ACOs, and know about the provider financial incentives. Importantly, Medicare consumers can't be locked in or perceive that they are locked in through penalties for out-of-network care. Educating consumers, Mr. Baker argues, is best done by a provider and should include information about care coordination, quality metrics, and rights and responsibilities.

  When patients understand the benefits of ACOs and understand that they have a choice, most will likely be comfortable participating. To consumers, the concepts of ACOs and patient-centered medical homes are very similar. The benefits of these types of organizations—high-quality care delivered through a coordinated network of providers—can be a strong incentive for patients to participate. But the ACO must deliver on these promises to show value.

Participant Discussion

- **Consumer loyalty.** If ACOs provide the level of care that is envisioned, they have the potential to build high levels of consumer loyalty. In Dr. Walters' experience in the PGP demonstration, patients loved the outreach and the care coordination, which have improved the connection between patients and the practices.

ACO and Shared Savings: Implications for Hospitals and Hospital Markets

Moderator: **Stuart Altman, Ph.D.**, *Professor of National Health Policy, Brandeis University*
Presenter: **Jeff Goldsmith, Ph.D.**, *President, Health Futures, Inc.*
Panelists: **Nancy Foster**, *Vice President for Quality and Patient Safety, American Hospital Association*
Susan DeVore, *President and CEO, Premier healthcare alliance*
Susan DeSanti, *Director of Policy Planning, Federal Trade Commission*

Overview

Optimists believe that ACOs and shared savings programs are an important first step in driving greater delivery system coordination that will help increase the value of healthcare. Skeptics are worried that the fervor created by ACOs will lead to market consolidation as hospitals merge and acquire physician practices. And insurers are concerned that as more Medicare patients join ACOs, hospitals will look to make up reimbursement deficits from private payers.

The panelists agreed that ACOs are just one of many different mechanisms that could help to improve the performance of the healthcare delivery system. New payment systems that reward value and encourage competition are essential to support desired delivery system change.

Context

Under shared-savings models that Medicare proposes for its ACO program, health systems will be encouraged to expand preventive care and reduce unnecessary hospital admissions. In most regions, hospitals control most of the administrative infrastructure and capital needed to make systemic changes in healthcare delivery. Therefore, hospitals will be partners or leaders in ACO development, but many believe that long-term savings will require reducing hospital utilization. In the short run, most hospital costs are fixed, and profitability depends on meeting volume targets. A key question is whether hospital-centric ACOs can benefit financially from shared savings without replacing lost admissions. If they cannot, it will have negative implications for potential Medicare savings, private insurance rates, and the stability of local hospital markets.

The panelists shared differing views about the potential implications of ACOs. Dr. Goldsmith expressed concerns, while Ms. Foster and Ms. DeVore were more optimistic. Ms. DeSanti described the role of the Federal Trade Commission (FTC) in ensuring competition.

Key Takeaways (Goldsmith)

- **The hospital market is currently driven by fear.**

  Dr. Goldsmith sees ACOs as one of many worthy ideas to move away from fee-for-service reimbursement in Medicare. However, ACOs have recently dominated the conversation in the provider community. Dr. Goldsmith termed the level of industry anxiety as unprecedented, and said that this is driving the following actions by hospitals:

  —*Acquiring physician practices.* Many hospital CEOs believe their hospitals need to employ physicians to be a viable ACO. So, hospitals are buying practices to get physicians and their patients. (Dr. Goldsmith mentioned that some hospitals are telling physicians that to participate in the hospital's ACO, they must bring their private insurance patients to the hospital). He sees physicians selling their practices because they have no ability to manage their business risk and because many no longer want to work long hours or manage their own practice.

  Dr. Goldsmith sees an emerging problem because hospitals' revenue yield on acquired practices is declining sharply and economic losses are mounting. He sees hospitals losing billions of dollars on practice acquisitions nationally, and looking to recoup those losses with higher private insurance rates.

  > *"There is an acceleration of hospitals rolling up physician practices in the name of aligning incentives. This is leading to huge economic losses [for hospitals] from overpaying for practices."*
  > — Jeff Goldsmith

  —*Engaging in M&A.* Dr. Goldsmith also sees a sharply rising level of hospital merger activity as hospitals rush to acquire or be acquired. But these acquisitions don't necessarily lead either to greater coordination or reduced cost, and they can distract senior managers from transforming healthcare.

  —*Determining the level of risk they can accept*. The transition away from fee-for-service reimbursement will require hospitals to be more sophisticated in their contract negotiations and in managing cash flow. Organizations are trying to determine how much risk they can assume given their relationships, IT infrastructure, and board.

  Of concern to Dr. Goldsmith is that mergers and acquisitions of physician practices will result in distracted hospital management, huge financial losses, and a concentration of provider power in many markets.

- **The Affordable Care Act was not a moderate reform; many provisions beyond ACOs will fundamentally restructure the health insurance market.**

  The Affordable Care Act creates a new entitlement program that will add 15–20 million new customers to the private insurance pool. Its implementation will continue to be a major political issue, with large amounts of federal spending and huge risks. The hospital industry needs to focus on all of these new changes, not just the ACO provisions which Dr. Goldsmith christened "hospital Mad Cow disease."

  These changes have implications far beyond the hospital market. As the number of Medicare and Medicaid patients increases, hospitals will try to make up financial deficits caused by low public payer reimbursement by increasing their rates to private insurers ("cost shifting"). In some areas, hospitals with market power have increased their rates by 30–40%. As a result, private health insurers will have to increase their rates. But doing so will

hurt the employer-customers and eventually will cause the public to blame insurers for the increased costs of healthcare. While the private insurance market is not yet being impacted by the Affordable Care Act's restrictions on underwriting practices and rate increases, it could be hurt quickly and significantly.

In Dr. Goldsmith's view, to get healthcare costs under control, changes are needed to dramatically strengthen primary care and to reduce the number and complexity of payment transactions. He believes that hospitals should focus on developing episode payment contracts that reimburse for all care surrounding an admission, including any pretreatment and post-acute rehabilitation. Payers, providers, and policy officials must create an environment that promotes patient autonomy and choice, and competition based on quality and price.

Key Takeaways (Foster)

- **From the AHA's perspective, hospitals have mixed feelings about becoming ACOs but will devote much attention toward the concepts underlying ACOs.**

  Ms. Foster did not share Dr. Goldsmith's assessment of hospital hysteria, but admitted that hospitals are nervous. Hospitals are keenly aware that they need to change how care is delivered, especially as it pertains to readmissions. Hospitals are looking at ACOs as a vehicle that will bring greater focus on coordination, integration, safety, efficiency, and effectiveness. However, hospitals don't see ACOs as a silver bullet; transforming healthcare will take many changes.

  While interest in coordination and integration is high across the country, interest in ACOs differs substantially by geography and capabilities. Interest is high in places that are already affiliated with physician practices, where infrastructure and information technology are firmly in place, and where administrative systems are ready to take on patient-management tasks. But the many hospitals that do not possess this infrastructure are less interested in becoming ACOs and prefer other incremental steps to become more integrated and patient-centered. Many would-be ACOs are waiting for final federal policies regarding antitrust regulation and patient steering provisions. Because patient centeredness is critical, most AHA members would prefer to inform patients if they were enrolled in an ACO and communicate the implications for their care.

Key Takeaways (DeVore)

- **Providers are trying to change how healthcare is delivered; payment models need to follow.**

  Ms. DeVore, whose organization leads integrated care delivery collaboratives, acknowledged that there is a great deal of waste, unjustified variation, and overutilization in healthcare as well as continued safety and quality problems.

  Solutions to these problems lie in a coordinated healthcare delivery system. Once delivery is coordinated, many types of payment models, such as shared savings, can be effective. However, Medicare's shared savings program is just one model. The hospital and physician-group participants in the Premier healthcare alliance are working with private payers on various ACO models. Every geographic area has unique characteristics that will require different models.

  Through a rigorous assessment process, the hospitals and health systems that are participating in the collaboratives have identified 150 operating capabilities required to achieve the goals of integrated care delivery. They have also identified several capabilities that have some urgency, including but not limited to physician integration models that are proven clinically and economically; care delivery models/maps that extend across the entire continuum of care; and payer contracting models.

  The context for these models is different than when capitation was tried in the 1990s. There is now more data and transparency on safety and quality; there is superior information technology and funding for national IT infrastructure; and there are stronger partnerships between payers and providers. This context makes Ms. DeVore optimistic about coordination in healthcare delivery.

  But simply implementing an ACO is not the solution. Healthcare stakeholders must come together to agree on standards for top performance, identify top performers, and then scale their best practices. Bringing about the changes that are necessary will take years and we should all keep the long view in mind, even as we recognize the short-term wins necessary to maintain reform's momentum.

Key Takeaways (DeSanti)

- **From the FTC perspective, competition is important to achieve lower healthcare costs.**

  Ms. DeSanti (speaking for herself, not the FTC) expressed the view that competition can and does work in health- care markets to lower costs, improve quality, and promote innovation. Various empirical studies have provided evidence to support that view. Moreover, payers consistently have told the FTC that, in markets that lack competition, providers with market power can and do raise prices. Without substitutes to turn to, the payers must pay the increased prices.

  > *"We [at the FTC] don't believe there is a way to get healthcare costs down that does not rely significantly on competition. Without compet-ition, where is the incentive to lower costs? "*
  > — Susan DeSanti

- **The FTC will be looking closely at ACO-related consolidation that might inhibit competition.**

  The FTC recognizes that ACOs will spur new partnerships between hospitals, physician groups, and other healthcare delivery organizations that have the potential to lower costs and improve quality. But the FTC is also sensitive to concerns that ACO development will result in provider consolidation. The FTC will pay close attention to the M&A activity that takes place related to ACOs and will evaluate hospital mergers and physician practice acquisitions for potential anti-competitive effects.

  Hospitals wanting to align (rather than acquire) with physician practices should look closely at the proposed ACO antitrust policy statement. The statement provides an expanded safe harbor for certain collaborations, describes conduct that would make antitrust scrutiny more likely, and outlines an expedited

review process for ACOs. The policies related to ACOs are currently open for comment and all comments are encouraged.

Participant Discussion

- **Shared savings enough of an incentive?** Dr. Goldsmith and Ms. DeSanti both commented on the relative weakness of shared savings incentives, where providers are not at risk for losses.

> *"To me, managed care without the risk is like a gin and tonic without the gin. It's the risk that forces you to make difficult choices."*
> — Jeff Goldsmith

  In response, one participant reflected on the fear providers still hold from the 1990s after they suffered losses in the HMO era. He commented that even if ACOs and shared savings are not the optimal solution for healthcare coordination, they provide a stepping-stone to help groups to start collaborating.

- **Competition vs. regulation.** Dr. Altman compared competition to regulated models for lowering costs, where the government sets insurance prices and monitors price increases. This too, he argues, may promote consolidation. Ms. DeSanti said that studies of Medicare patients have shown that when prices are regulated, quality improves because providers compete based on quality. She added that states may choose to replace competition with regulation. But to comply with federal antitrust law, they must have: 1) a clearly articulated state policy favoring regulation over competition; and 2) active supervision of the regulatory framework they set up.

- **Risk of cost shifting.** Payers are concerned that as Medicare patients enroll in ACOs, costs will be shifted to the private sector. The increasing number of Medicaid and dual-eligible patients could cause further cost shifting. As the ACO pilot moves forward, they suggest examining total health spending for the ACOs, not just Medicare spending.

- **Greater use of advanced practice nurses.** A strategy that ACOs may consider is increasing the use of advanced practice nurses. However, in many states, physician organizations are seeking legislation to limit the roles that nurses can play. Ms. DeSanti commented that the involvement of professional associations to limit other types of mid-level professionals is common (e.g., dental hygienists, paralegals). Upon the request of a state legislator, the FTC staff will analyze the likely competitive effects of limiting the scope of practice of mid-level professionals, but this is most effective when research exists to show the care provided by mid-level professionals is not as safe or results in equivalent outcomes as care from a professional. Ms. DeSanti is the right contact person for those who are concerned about proposed state legislation that would limit the scope of practice of mid-level professionals.

Physician demographics and physician-practice acquisitions. Dr. Goldsmith argued that the growth of hospital-led ACOs may be spurred by the unique characteristics of today's physicians. The older generation of doctors (38% are now over age 55) worked continuously, cherished their independence, and were raised to be suspicious of hospitals and health systems. But many of these doctors lost part of their retirement in the financial crisis and are now facing large information-technology expenditures in their practices. They view selling their practices to hospitals and becoming employees as a partial retirement solution. In contrast, younger physicians seek a career that guarantees them a steady paycheck, along with the ability to spend time with their families. These factors will hasten the trend of physician-practice acquisitions, which may lead to a more rapid growth of ACOs or other types of integrated delivery systems.