

Keith J. Mueller, Ph.D.

Director, RUPRI Center for Rural Health Policy Analysis
Head, Department of Health Management and Policy
College of Public Health
University of Iowa

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The Patient Protection and Affordable Care Act Changes the Landscape

- Value Based Purchasing is here to stay
- Quality reporting continues to evolve
- Now part of a national plan
- Activities of the new Center of Medicare and Medicaid Innovation

Section 3022: Medicare Shared Savings Program

- Emphasis of the title is intentional
- Coordinate care in the FFS program through Accountable Care Organizations (ACOs)
- Must meet quality standards
- Accountable for patients for at least three years

ACOs: Eligibility

- Could start with physicians
- Could start with hospitals
- Need formal legal structure to receive and distribute funds
- Need 5,000 beneficiaries

- Leadership and management structure
- Process to promote evidence-based medicine, report data on quality measures, coordinate care
- Meet patient-centeredness criteria

Savings

- As compared to benchmark amount (benchmark to be determined by CMS)
- Meeting clinical standards in process, outcomes, patient experience, utilization (latitude for CMS)
- Sustaining the savings a challenge

Some Troublesome Assumptions Being Modified

- Requires large multi-disciplinary practices: one study published in May 2010 Health Affairs found 3.6% lower annual costs from group practices
- Minimum population requirements meet for one carrier at a time or for multiple carriers?

Flexibility: The three tiers approach (Shortell, Casalino and Fisher in July 2010 Health Affairs)

- Tier 1: minimal financial risk but eligible to receive shared savings and bonuses for meeting quality benchmarks and reduces per beneficiary spending
- Tier 2: eligible to receive greater proportion of savings if achieve spending rates below target, but also at risk for spending above target; partial capitation; report more comprehensive data
- Tier 3: full capitation or extensive partial capitation and bundled payments; highest potential reward but with greatest risk

Measuring Performance of ACOs (from Health Affairs May 2010 article by McClellan et al)

- Care Coordination: hospital readmissions, depression follow-up and management to reconciled medication list and discharge plan
- Care effectiveness/population health: cancer care screenings to quality of life and functional outcomes

- Safety: testing for patients using high-risk medications to outpatient medication errors
- Patient engagement: physician instructions understood
- Overuse/efficiency: imaging for low back pain during first 30 days to episode-based resource-use metrics linked to quality of life, functional, and patient engagement measures

Lessons From Large Organizations: Scott & White attributes of Ideal Systems

- Information continuity
- Care coordination and transitions
- System accountability
- Peer review and teamwork for high-value care
- Continuous innovation
- Easy access to appropriate care

Competencies Found by AHA Review of Brookings/Dartmouth, Baylor Med School, Premier

- Leadership
- Organizational culture of teamwork
- Relationships with other providers
- IT infrastructure of population management and care coordination

- Infrastructure for monitoring, managing, and reporting quality
- Ability to manage financial risk
- Ability to receive and distribute payments or savings
- Resource for patient education and support

Other points made by AHA

- Spread of best practices
- Reach linkages between ACOs and public health/community resources
- Regional health information exchange

Key findings from Vermont ACO Pilot

- ACO cannot exist in a vacuum
- Working design for pilot built on three major principles
 - Local accountability for defined population
 - Payment reform based on shared savings
 - Performance measurement, including patient experience data, clinical process and outcome measures

- Pilots need capabilities in five areas to get started
 - Manage full continuum of care settings and services, beginning with PCMH
 - Be financially integrated with both commercial and public payers
 - HIT platform that connects providers in the ACO and allows for proactive patient management
 - Physician leadership, as well as commitment of hospital CEO
 - Have process improvement capabilities to change clinical and administrative processes

Policy Advice

- Set realistic expectations
- Consider pairing new starts with existing ACOs
- Provide technical assistance to develop legal and other structures to support new relationships
- Provide practice redesign technical assistance

- Structure shared savings to consider historic cost-efficiency
- Offer various levels to financial risk
- Encourage other payers to develop healthcare delivery and payment models to parallel Medicare ACO program

Resources

- Learning Network:
 https://xteam.brookings.edu/bdacoln/P
 ages/home.aspx
- Access Learning Network through: <u>http://www.brookings.edu/health.aspx</u>
- Presentations from RUPRI on our sites (following slide)

For Further Information

The RUPRI Center for Rural Health Policy Analysis

http://cph.uiowa.edu/rupri

The RUPRI Health Panel

http://www.rupri.org





Dr. Keith J. Mueller

Department of Health Management and Policy College of Public Health 200 Hawkins Drive, E203 GH Iowa City, IA 52242 319-384-5121

keith-mueller@uiowa.edu