



# Accountable Care Organizations: How to Thrive in this Brave New World

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- I have no significant financial relationships with industry to disclose 2008-2020.

# Outline

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- Health Care Reform
  - History
  - Current
- Pharmacy in the ACO
  - Overall
  - Mental Health
- Questions, Discussion

# Quotes

**For every complex problem, there is an answer that is clear, simple, and wrong.**

**-H.L. Mencken**

**When I was young, I thought that money was the most important thing in life; now that I am old, I know that it is.**

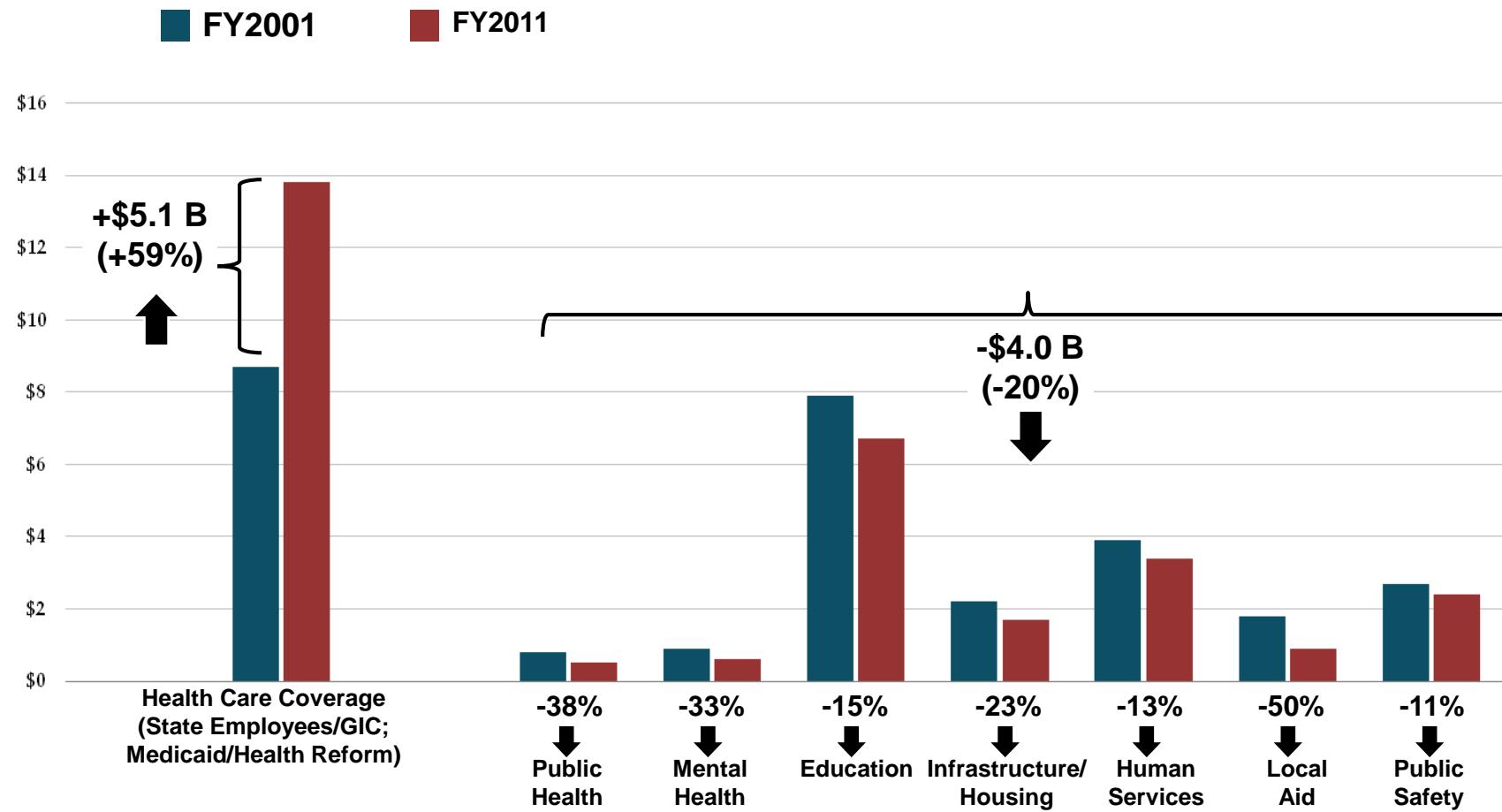
**-Oscar Wilde**

# Health Care Reform: History

- A “Cost plus” business
  - Profit & sustainability inherent in compensation
- “Fee for Service” Compensation Model
  - Rational actors maximize profit by increasing unit price and volume
    - Incentivized and produced growth of US Healthcare spend
- The Consequence:
  - Health care spending up, up, up...
    - 17.9 % of GDP in 2011
      - Medicare was 3.7% of GDP; predicted to go to 5.1% by 2035 (Chernew, Health Affairs)

# Consequence from a public policy view

## *Massachusetts state discretionary spending*

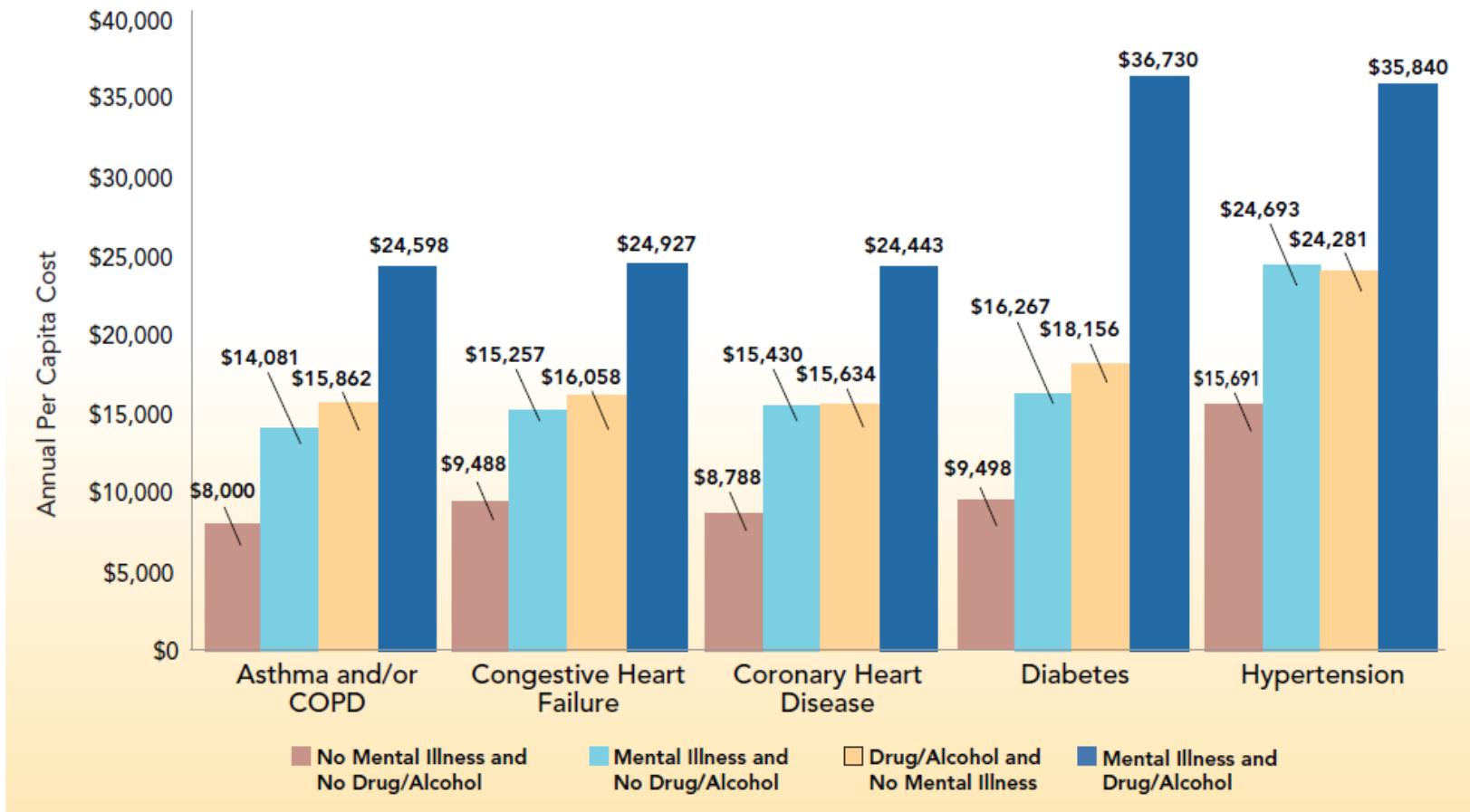


# Policy Response: Budget = Risk

- Global budgets replace cost plus
  - Budgets limit overall spending with cap, thus controlling spending risk
  - Fee For Service to capitation compensation
    - Flips incentive base from payer to provider
    - Provider focus on population, prevention, appropriateness and effectiveness of intervention
      - Raised profile of Mental Health

# Per Capita Medicaid Costs

## *Implications of Behavioral Health*



Source: Center for Health Care Strategies report: *Faces of Medicaid: Clarifying Multimorbidity Patterns to Improve Targeting and Delivery of Clinical Services for Medicaid Populations*, December 2010. Available at [http://www.chcs.org/publications3960/publications\\_show.htm?doc\\_id=1261201](http://www.chcs.org/publications3960/publications_show.htm?doc_id=1261201).

# Evolution of Risk in Capitation Models

- Original capitation: PCP as risk holder
  - Problems:
    - Ethical
    - Data availability
    - Culture (doctors and patients)
    - Doctors bad as managers (of business)
- Next: “Managed Care”
  - UM/PA by payer
  - Gatekeeping
- Evolution: Pay for Performance (P4P)
  - Withholding fractions of payments until metrics satisfied
  - Usually 10-15% of fees
- Current: Capitation; risk corridors
  - AQCcs, Value-based Contracting, ACOs, Bundled payments, MACRA/MIPS/APM

# Risk Models

- Pay for performance (P4P)
  - Additional payment incentives for meeting performance metrics
    - Ex. imaging
- Alternative Quality Contract (AQC)
  - Step beyond P4P
    - Limited risk based on additional Quality and Performance Metrics
    - More complex risk and incentive sharing model
- Accountable Care Organization (ACO)
  - Risk corridors (minimum and maximum compensations)
  - Types of ACOs & supporting federal infrastructure
    - MACRA, MIPS/APM (alphabet soup...)

# MACRA

- MACRA: Medicare Access and CHIP Reauthorization Act
  - Started 4/16/15
  - Replaces Sustainable Growth Rate (SGR)/Physician Fee Schedule (PFS) update
    - CHIP = Children's Health Insurance Program

# MIPS

- MIPS: Merit-based Incentive Payment System
  - Starts 2019
  - Limited risk corridors up and down
  - Score based on
    - Quality (ex screening for depression, breast/colorectal cancer, fall risk; HbA1 c control; ASA for CVD): 30%
    - Resource Use 30%
    - Clinical Improvement Activities (PHM [use of registries, prevention], improved access, care coordination [telehealth], engagement [care plans for complex patients, SDM]) 15% and Meaningful Use (EHRs) 15%

# APM

- APM: Alternative Payment Model
  - Complex rules,
    - But essentially a 5% upside for advancing levels of up- and downside risk in ACOs
      - 25% of Part B payments in 2019-20 going to 75% of Part B payments by 2023

# Accountable Care Organizations

- CMS: “Groups of doctors, hospitals, and other healthcare providers who come together voluntarily to give coordinated high-quality care....”
  - Coordinated care =
    - ‘...right care at the right time...’
    - ‘...avoiding unnecessary duplication of services’
    - ‘...preventing medical errors.’
    - focus on chronic illness
    - shared savings

# Types of ACO's & Incremental Evolution

- Shared Savings
  - Focus of FFS Medicare, first step, year end reconciliation, limited share of upside
    - 480 programs in 50 states covering 9 million people
- ACO investment model
  - For shared savings ACO to test pre-paid savings in rural/underserved areas
    - 45 programs in 38 states covering 487,000 people
    - Evolved from Advanced Payment Model (sunset)

# Types of ACO's (Cont.)

- Pioneer ACO
  - Next step from Shared Savings/Advanced payment models for groups able to do Population Health Management (PHM)
    - Sunset (9 groups finishing up)
- Next Generation ACO
  - Next step from Pioneer
    - 44 groups
  - More risk, somewhat more flexibility

# Population Health Management

- Avoiding unnecessary ER visits
- Avoiding unnecessary admissions
- Discharge planning
- Avoiding unnecessary readmissions
- Integration with skilled nursing facilities
- End of life / Hospice enrollment
- Chronic Disease management
- Patient Reported Outcome Measures
- Virtual Visits / Telehealth
- Virtual Consults
- Care Redesign
  - Diabetes
- Patient Centered Medical Home
- Integrated care management program
- Population Health Coordinators
- Variation analyses & reporting
  - Imaging
  - Routine & high-cost labs
  - **Pharmacy**
- Stewardship groups
- Radiology Order Entry
- Procedure Order Entry
- Patient experience
- Meaningful Use & EMR integration
- **Pharmacy**

# MGH CMS DP

## Background

- *Timeline:* 2006 -11
- *Concept:* Improve the quality and reduce the cost of care for high cost Medicare patients
- *Patient characteristics:* >20% annual mortality, average age 76, more than half with a behavioral health diagnosis

## Intervention

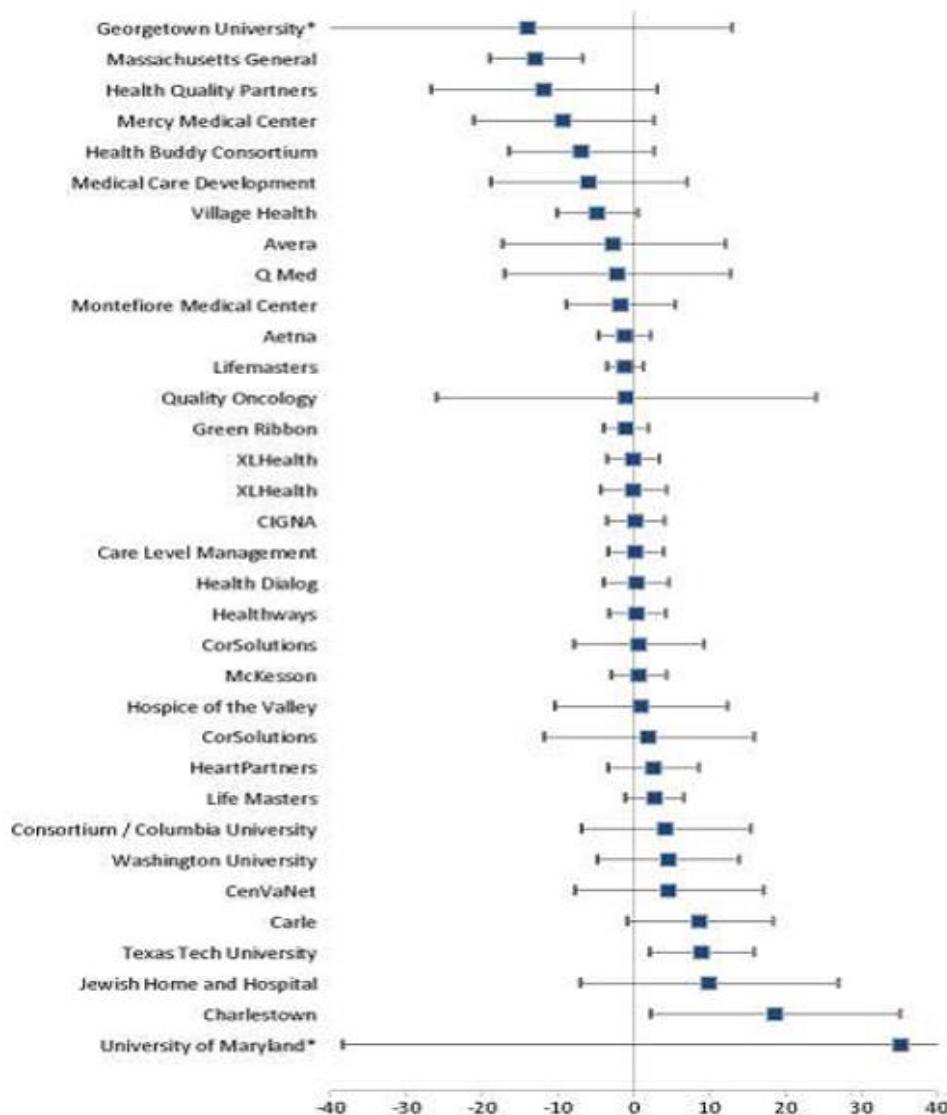
- Care managers embedded in primary care practices to coordinate the care of patients at risk for poor outcomes
- Supported by health IT (universal EHR, patient tracking, home monitoring), mental health and Rx management resources

# Typical Patient



# Results 1

**Figure 1.**  
**Percentage Effect of Disease Management and Care Coordination Demonstrations on Regular Medicare Expenditures**



Lessons from Medicare's  
Demonstration Projects on  
Disease Management and  
Care Coordination

Lyle Nelson  
Congressional Budget Office  
January 2012  
Working Paper 2012-01

# IMPACT OF ACOs

- CMS reports that the 20 Pioneer and 333 Shared Savings ACOs saved more than \$411 million in 2014 while increasing quality measures over fee-for-service\*
- An independent evaluation reported \$384.2 million in savings from the Pioneer Model alone\*\*
- Pioneer ACOs perform fewer low-benefit services\*\*\*

\*Medicare ACOs Continue to Improve Quality of Care, Generate Shared Savings, CMS Published online August 25, 2015.

<https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2015-Press-releases-items/2015-08-25.html>

\*\*Nyweide DJ, Lee W, Cuerdon TT, et al. Association of Pioneer Accountable Care Organizations vs traditional Medicare fee for service with spending, utilization, and patient experience. *JAMA* 2015; 313:2152-61

\*\*\*Schwartz AL, Chernew ME, Landon BE, McWilliams J. Changes in Low-Value Services in Year 1 of the Medicare Pioneer Accountable Care Organization Program. *JAMA Intern Med.* Published online September 21, 2015.

<http://archinte.jamanetwork.com/article.aspx?articleid=2442504>

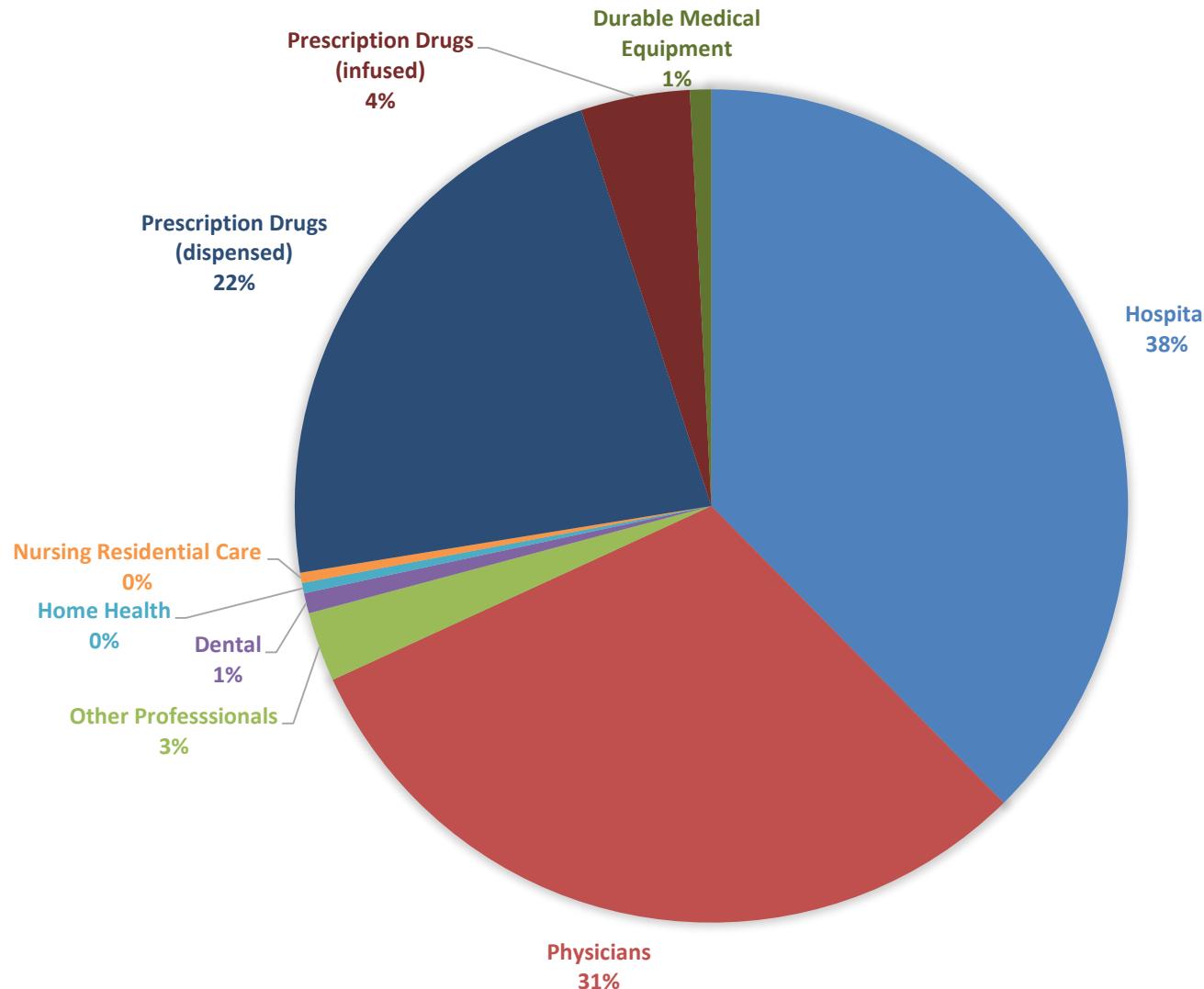
# ACO Results (Cont.)

- Health Care reform (including ACOs) slowed growth
  - Real per person/year medical spend 0.9% 2011-13
- But rate of growth has increased again
  - 3.4% 2014-16. (DM Cutler JAMA Aug 17)
  - Demographic trends ensure increased demand/utilization
  - Technological advances increase unit costs
  - ACOs may drive up price by consolidation/market impact
  - 13/32 original Pioneer ACOs dropped out....

# Pharmacy in the ACO

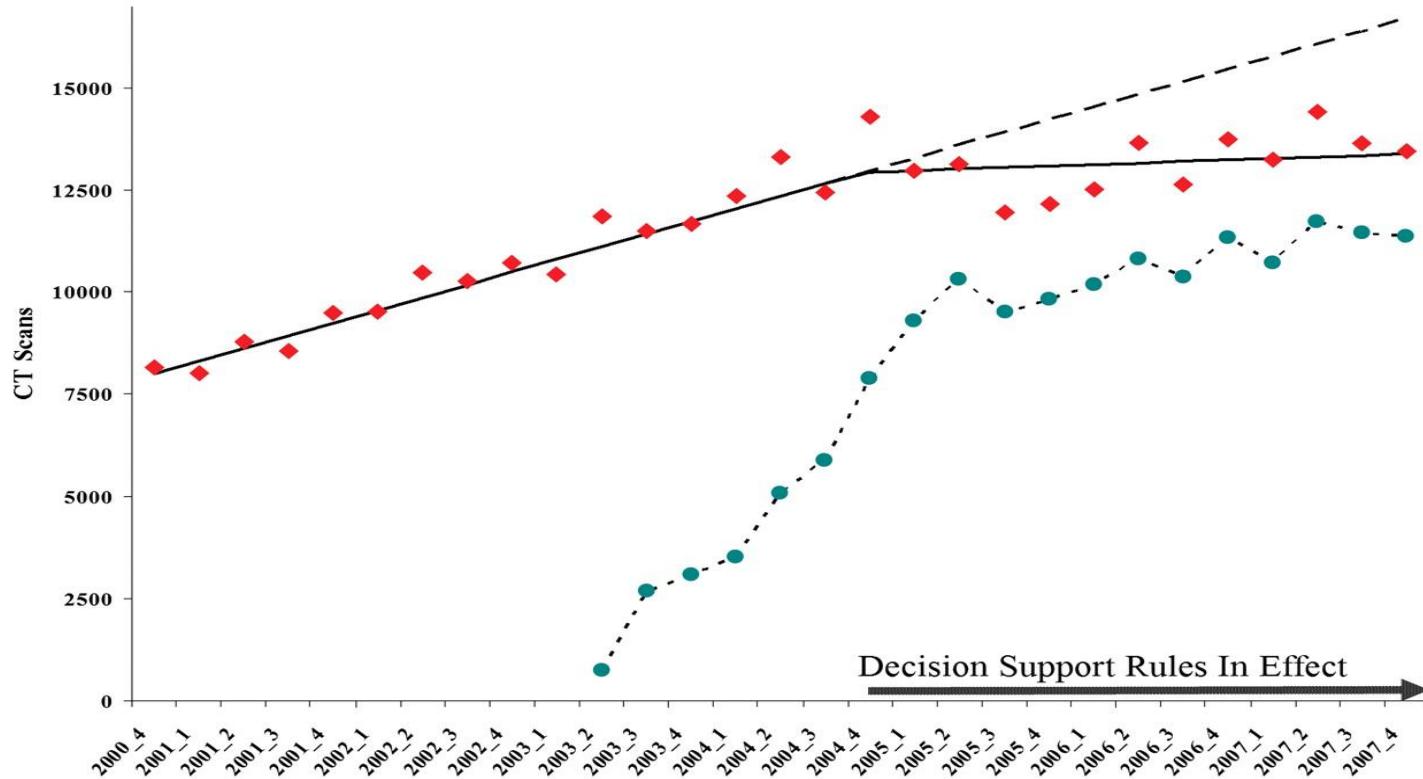
- Academic detailing
- Therapeutic substitution
- EMR-based decision support (CDS)
- Prescriber Variation Reporting
- Adherence
- Big focus on Specialty Drugs
  - Medical vs Pharmacy budget

# COMMERCIAL PAYERS, MAJOR CATEGORIES

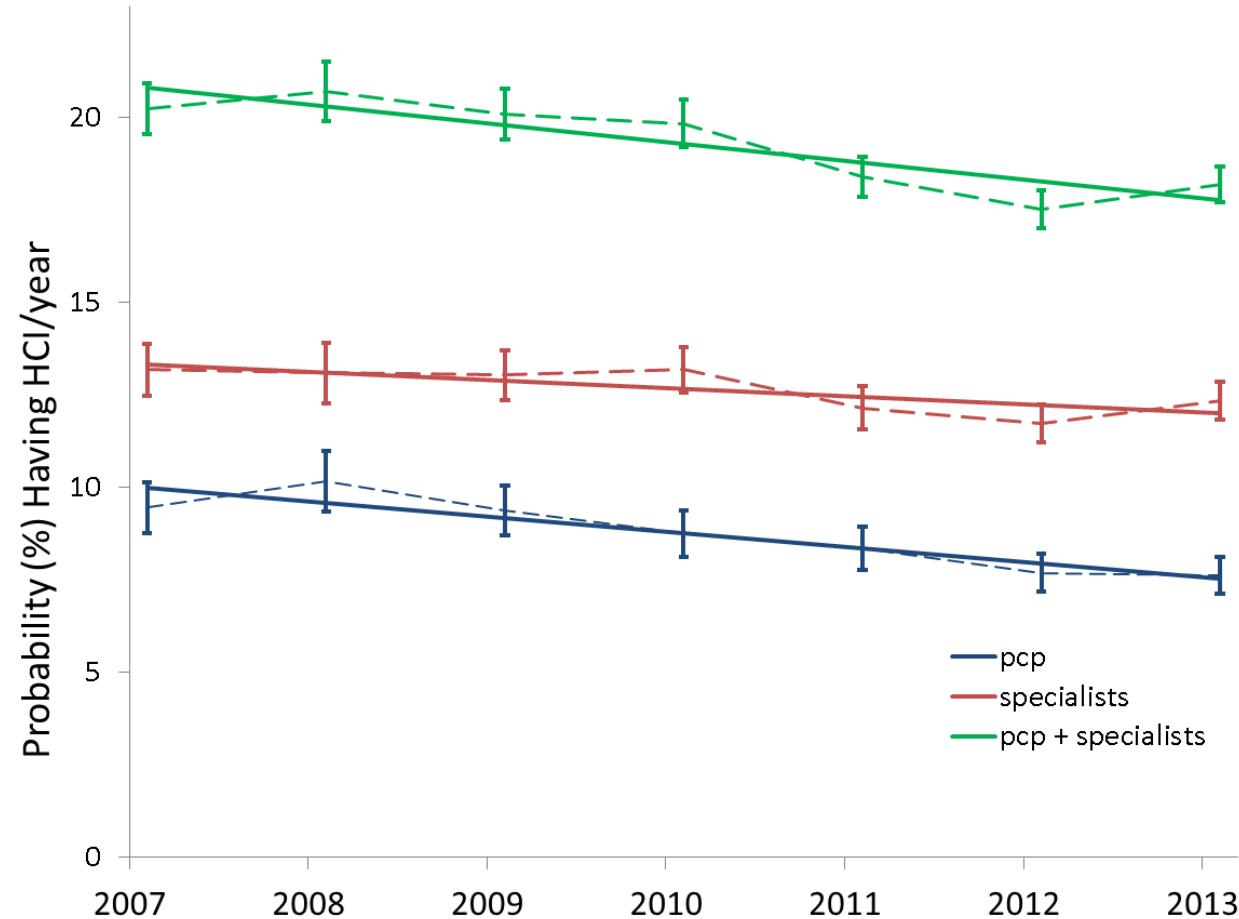


# Bending the cost curve

Sistrom et al Radiology 2007

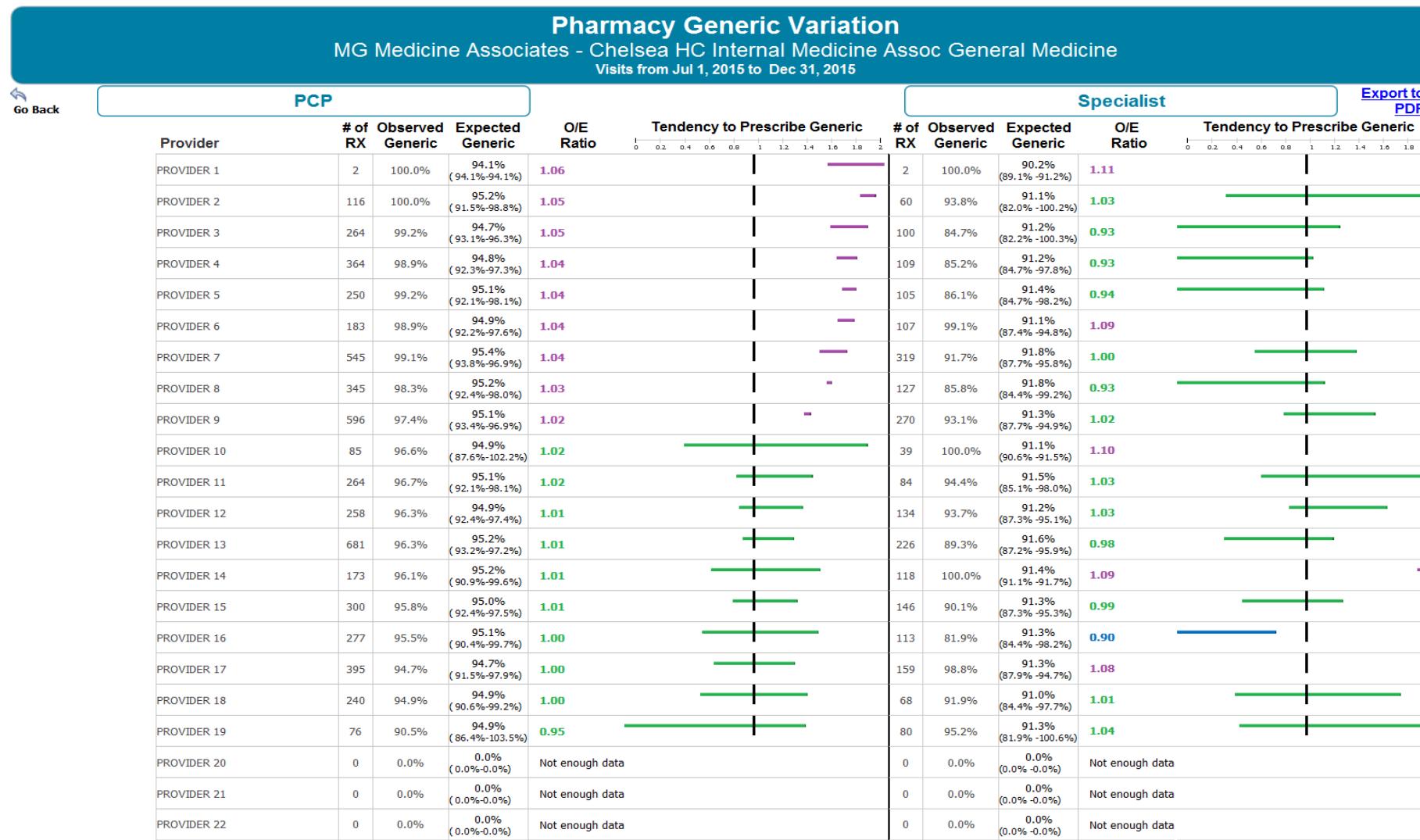


# Impact of CDS on Imaging



Weilburg et al Radiology 2017

# Drill Down into Pharmacy - Generic



**Key:**

- █ Significantly higher than the study mean
- █ Not significantly different from the study mean
- █ Significantly lower than the study mean

# Drill Down into Pharmacy - Cost

**Pharmacy Cost Variation**  
 MG Medicine Associates - Chelsea HC Internal Medicine Assoc General Medicine  
 Visits from Jul 1, 2015 to Dec 31, 2015

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**PCP**

Provider	# of RX	Observed Patients w/Rx	Expected Patients w/Rx	O/E Ratio	CI Expected vs Observed
PROVIDER 1	36	34	30	<b>1.39</b>	
PROVIDER 2	44	37	30	<b>1.34</b>	
PROVIDER 3	33	29	20	<b>1.30</b>	
PROVIDER 4	44	36	30	<b>1.27</b>	
PROVIDER 5	46	37	30	<b>1.25</b>	
PROVIDER 6	83	69	60	<b>1.24</b>	
PROVIDER 7	42	34	30	<b>1.09</b>	
PROVIDER 8	62	47	40	<b>1.04</b>	
PROVIDER 9	47	34	30	<b>1.03</b>	
PROVIDER 10	19	13	10	<b>1.03</b>	
PROVIDER 11	50	35	30	<b>0.93</b>	
PROVIDER 12	98	74	70	<b>0.93</b>	
PROVIDER 13	49	37	40	<b>0.92</b>	
PROVIDER 14	21	14	10	<b>0.90</b>	
PROVIDER 15	116	84	80	<b>0.88</b>	
PROVIDER 16	55	37	40	<b>0.84</b>	
PROVIDER 17	34	20	20	<b>0.82</b>	
PROVIDER 18	53	36	40	<b>0.81</b>	
PROVIDER 19	0	0	0	Not enough data	
PROVIDER 20	0	0	0	Not enough data	
PROVIDER 21	0	0	0	Not enough data	
PROVIDER 22	0	0	0	Not enough data	

**Specialist**

Provider	# of RX	Observed Patients w/Rx	Observed Avg Cost per Rx	Expected Avg Cost per Rx	O/E Ratio	CI Expected vs Observed
PROVIDER 1	34	34	542.4	478	<b>1.20</b>	
PROVIDER 2	37	37	192.6	343	<b>0.66</b>	
PROVIDER 3	29	29	727.1	302	<b>1.56</b>	
PROVIDER 4	36	36	166.4	295	<b>0.68</b>	
PROVIDER 5	37	37	606.0	356	<b>1.05</b>	
PROVIDER 6	69	69	515.1	430	<b>1.13</b>	
PROVIDER 7	34	34	339.6	327	<b>0.97</b>	
PROVIDER 8	47	47	234.0	328	<b>0.75</b>	
PROVIDER 9	34	34	587.9	345	<b>1.01</b>	
PROVIDER 10	13	13	167.5	337	<b>0.78</b>	
PROVIDER 11	35	35	435.7	387	<b>1.19</b>	
PROVIDER 12	74	74	360.3	453	<b>0.90</b>	
PROVIDER 13	37	37	552.2	332	<b>1.35</b>	
PROVIDER 14	14	14	206.2	310	<b>0.90</b>	
PROVIDER 15	84	84	342.6	364	<b>0.97</b>	
PROVIDER 16	37	37	540.6	333	<b>1.40</b>	
PROVIDER 17	20	20	176.5	345	<b>0.70</b>	
PROVIDER 18	36	36	209.2	346	<b>0.69</b>	
PROVIDER 19	0	0	0.0	0	0.00	Not enough data
PROVIDER 20	0	0	0.0	0	0.00	Not enough data
PROVIDER 21	0	0	0.0	0	0.00	Not enough data
PROVIDER 22	0	0	0.0	0	0.00	Not enough data

**Key:**

- █ Significantly higher than the study mean
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# Price Setting

- Market? Regulation? Cost-effectiveness analysis (ICER)?
  - Indication-based pricing
    - ICER
  - P4P
    - Kymriah (Novartis): CMS
    - Repatha (Amgen), Trulicity (Lilly): HPHC

# Institute for Clinical and Economic Review (ICER): Framework

“Sustainable High-Value Care for All”

“Long Term Value”

Comparative Clinical Effectiveness

Estimated Incremental Cost Effectiveness

Other benefits/costs/consequences

Context

Short Term

‘Budget’

Long term: cost offset over life of patient(s)

EICE: \$/QALY and actual drug price key issues

CCE: multiple sources of evidence (RCTs + ‘RWD’); clarity of evidence provenance and limitations

Other/context: patients and system gain value outside purely clinical outcomes; medical care is evolving

Applicable to devices and care system improvements as well as drugs

“Quite simply: budget impact, and not long-term cost-effectiveness, determines how affordable health care insurance will be in coming years and shapes what health care can be provided with the resources available. And yet, the perverse influence of an undiluted focus on budget impact cannot be overstated. A narrow short-term perspective blinds policy makers, insurers, and providers to the need to forge efforts to reshape the delivery system and reframe payment mechanisms to “make room” for new, and potentially expensive interventions that will help patients and pay off in the end. Therefore, if an economic analysis of new interventions is focused only on the short term, relying solely on budget impact estimates, patients and the health care system will be the ultimate losers. “

ICER

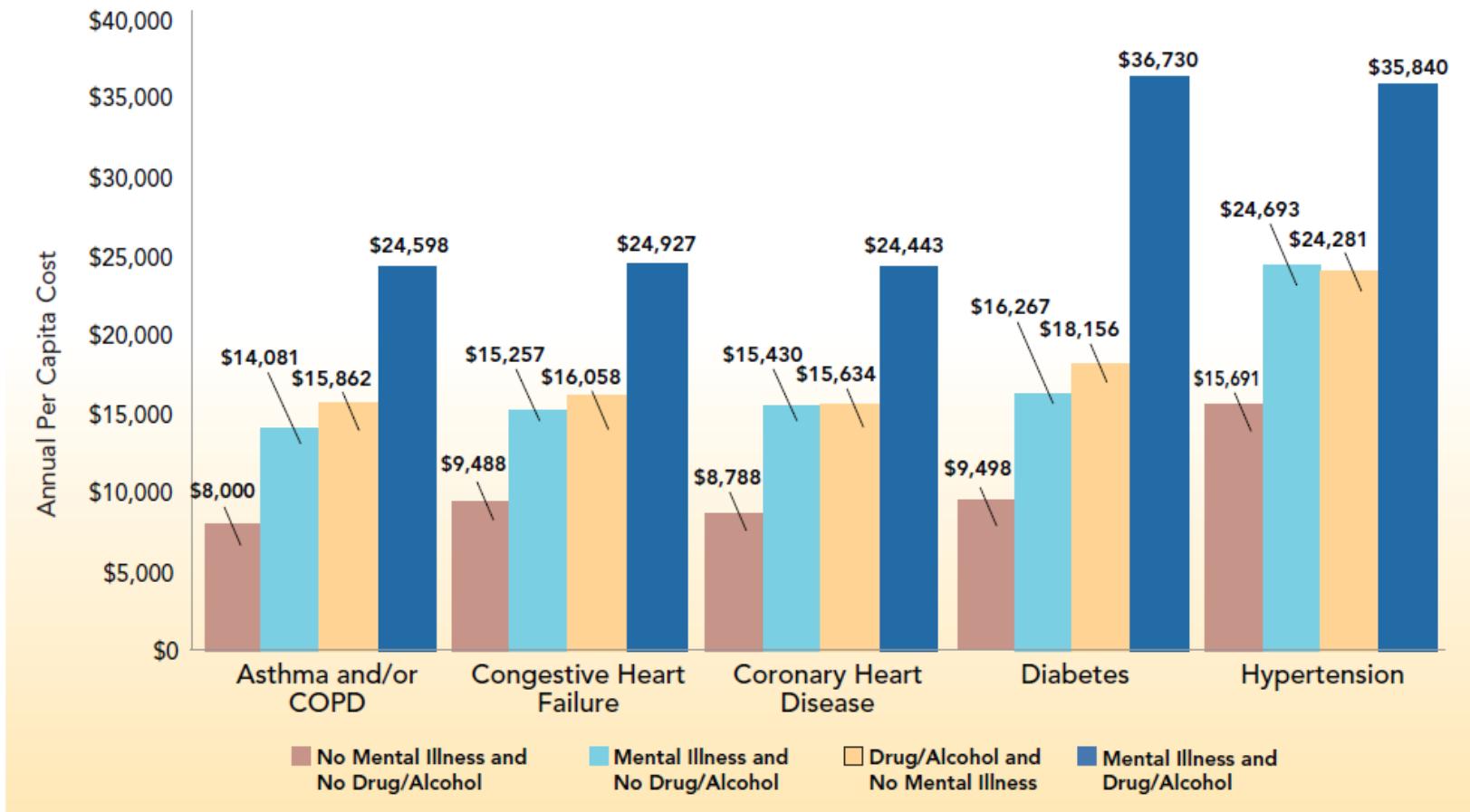
# MH Pharmacy: Cost Offset

(Reuters Health July 17) – ‘An effort by the Netherlands to save money on mental health care by raising patient co-pays produced \$15 million in short-term savings but ended up adding \$29 million to the costs of treating bipolar and psychotic disorders...’

JAMA Psychiatry July 17

# Per Capita Medicaid Costs

## *Implications of Behavioral Health*



Source: Center for Health Care Strategies report: *Faces of Medicaid: Clarifying Multimorbidity Patterns to Improve Targeting and Delivery of Clinical Services for Medicaid Populations*, December 2010. Available at [http://www.chcs.org/publications3960/publications\\_show.htm?doc\\_id=1261201](http://www.chcs.org/publications3960/publications_show.htm?doc_id=1261201).

# What does all this mean re my job?

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- Perspective of your contact
  - Individual clinician, researcher, manager
- Show value
  - Individual patient
  - System (cost offset?)

# Thank you...

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- Questions?

# Questions, Discussion