

How the Oregon Health Fund Board can improve the quality of care and slow the rate of cost growth

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Familiar problems...

- A complex, fragmented, & confusing system
- Very little coordination
- Very little or no incentive to limit care
- Inadequate data to assess cost-effectiveness (or even cost growth or utilization trends)
- Current innovations too incremental to really “bend the cost curve”?
 - Pay for performance?
 - Certificate of Need?
 - Encouraging patient decision aids?
 - Etc etc

A “bigger picture” approach

- Define Accountable Care Organizations
 - Elliot Fisher & Dartmouth Group have worked on these extensively
 - See e.g., Fisher et al. *Health Affairs* 2006.
- Use the ACO to report outcomes, utilization rates, and spending
- Three rationales:
 - Performance measurement
 - Local accountability
 - Payment reform

Defining the Accountable Care Organization: Empirical Observations

1. Almost all physicians work within or around a single hospital and can be directly affiliated with that hospital using claims data
 2. Patients cared for by these empirically defined medical groups can be identified through claims
 3. Most of the care for these patients is provided by the empirically defined medical group or a referral hospital and its staff that are readily identified
- Thus: these empirically defined hospital / medical staff groups (Accountable Care Organizations) provide care to relatively large and stable populations (providing statistical precision in both outcome and cost measures)

Defining the Accountable Care Organization: How to

- Step 1: Assign physicians to hospitals
- Step 2: Assign patients to hospitals
- The resulting “network” of physicians and patients assigned to a particular hospital may be treated as an ACO and provides a region for providing quality measurements (and perhaps rewards)
 - No formal contracting agreement binds the physicians or patients assigned to an ACO.

Now you've defined your ACO(s)

- What does that get you?
- First, let's look at performance measurements
- It could get you this...

	ACO #1	ACO #13
Number of beneficiaries	50,000	60,000
<u>Quality of ambulatory care</u>		
Colorectal cancer screening	12.0%	15.0%
Diabetic eye exams	41.0%	44.2%
<u>Hospital utilization and outcomes (per 1000 beneficiaries)</u>		
Emergency department visits	800	700
Short-stay hospital discharges	400	307
Acute care institutional days	5	4
In-hospital mortality, CABG	0.02	0.01
MRI scans	54	27
<u>Measures of coordination</u>		
Concentration of medical staff at primary hospital	60.7%	84.3%
Different physicians seen (average)	5.1	4.3
<u>Spending per beneficiary</u>		
Physician services	\$3000	\$2200
Acute care hospital	\$2600	\$2200
Total	\$5600	\$4400

ACO Rationale #1: performance measurement

- Opportunities for comparing outcomes among high intensity sites vs. low intensity sites
 - Not just outcomes among individuals undergoing a selected procedure
- Measures spending per beneficiary
 - Not just hospital prices
- Measures and promotes coordination between physicians, clinics, and hospitals
 - Not just silos
- New set of aggregated data to improve the ability to do technological assessments *and* outcomes assessments

ACO Rationale #2: local accountability

- We know that cost growth is a major challenge to health reform
- Local decisions (MRI purchases, ICU wings, high-tech devices) are a first step in the chain to more-intensive practice patterns and the overuse of services
- ACO-level measures of quality and costs would bring the impact of such decisions to light
- The effects of expansions of acute care facilities or recruitment of additional specialists would be more easily identified
 - The good and the bad
 - Not just a vague pass-through that is built into future premiums

ACO Rationale #3: linking ACOs and reimbursement

- Lots of ways to do this – a future consideration
- Reward ACO providers who achieve quality targets while reducing the growth of *overall* costs?
- Oregonians: “We think costs should grow at 6% per year, not the current 8%”
 - That’s the target
 - Give providers a bonus (e.g. 80% of savings) if they come in lower (4% growth)

Putting these together...

- ACOs are relatively easy to define
 - Does not mean abandoning or changing any reform options for covering the uninsured
 - Does not require new contractual agreements with physicians or hospitals
 - Does not need to be conducted on a statewide basis
 - E.g., could be piloted in selected regions in Oregon
- ACOs & performance measurement:
 - Broad, diverse set of measures possible (public health, too!)
 - Captures the entire continuum of care
 - Allows for assessment of investment of expensive & high intensity treatments
- ACO & local accountability
 - “Virtual home” - encourages coordination of care
 - Could foster the use of care management protocols
- ACOs & payment reform
 - Opens up possibilities of reforming the payment system
 - Providers could be given incentives to control total spending
 - Generate savings to the state/employers/individuals
 - Could be designed to have smaller relative impact on provider revenues
 - Deterrent to the “Medical Arms Race”

What are the potential savings?

- What's at stake?
- Assume that we spend this much in 2009 (rough numbers):
 - State spending (OHP) :\$1B
 - Employer spending: \$6B
 - Individual spending: \$3B
 - -----
 - Total: \$10B

How does \$10B grow? 8% vs. 6%

Year	Spending (8%)	Spending (6%)	Savings
2009	\$10B	\$10B	\$0
2011	\$11.6B	\$11.2B	\$0.4B
2013	\$13.6B	\$12.6B	\$1.0B
2015	\$15.9B	\$14.2B	\$1.7B
2017	\$18.5	\$15.9B	\$2.6B
2019	\$21.6	\$17.9B	\$3.7B

Other experiences

- Medicare Physician Group Practice Demonstration
 - Early results: some groups able to achieve higher quality and slower expenditure growth (currently contingent on performance payments)
- Vermont – under way?

Challenges?

- Current market/reimbursement system
 - Rewards the use of expensive, high intensity services
 - ACO is not a panacea
- Cultural challenges
 - Providers may resist accepting a degree of responsibility for the care of all of the patients within their ACO
- Legal obstacles to physician-hospital collaboration
 - Especially with regard to sharing potential financial gains/rewards
- Concentration of care in Portland?
 - Many physicians admit to multiple hospitals

Hospital	Concentration of care: Percent of all Evaluation and Management billing to assigned physicians in designated ACO
Willamette Falls	67%
Emanuel	51%
Providence Milwaukee	64%
OHSU	57%
Adventist	67%
Good Sam	61%
Providence Portland	73%
St. Vincent's	70%
Meridian Park	69%
AVERAGE	64%

How do we get there?

- Step 1: Define ACOs using Medicare, Commercial, and/or OHP claims data
 - Dartmouth group has already done this!
 - ACOs can be flexible;
 - if empirical definition does not work, physicians can suggest/create their own ACOs
 - ACO could include 2 or 3 hospitals
- Step 2: Use what we have started...
 - OHPR: Hospital Quality/Outcomes
 - Uses hospital discharge data
 - OHPR: Hospital Pricing
 - Uses commercial insurance claims
 - QualityCorporation: Ambulatory Quality/Outcomes
 - Uses commercial & Medicaid insurance claims
- ...but provide public performance at the ACO level
- Step 3: Encourage/incentivize controlling long-term cost growth

Exploring this model

- Builds on (and coordinates!) ongoing attempts to provide more public reporting
- Provides a framework for the State and Health Fund Board to align incentives and encourage desirable behaviors
 - E.g., encourage providers to focus on “planning” instead of “expansion”
- Aligned with models currently under consideration
 - Compatible with Medical Home model
 - Compatible with Medicare’s Physician Group Practice Demonstration
 - Compatible with recent MEDPAC report on pay-for-episode reimbursements
- Opportunities to learn from:
 - Medicare demonstrations
 - Vermont proposal
 - Dartmouth group

Thank you...

...and questions?

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