ACCOUNTABLE CARE ORGANIZATIONS

House Committee on Health Care
February 14, 2014

Trinka Kerr
Chief Health Care Advocate

Julia Shaw
Health Care Policy Analyst

Office of Health Care Advocate
Vermont Legal Aid

Overview

- What is an ACO?
- Goals/risks
- ACOs in the United States
- ACOs in Vermont
- What is the evidence?
- Concerns
- HCA involvement

What is an Accountable Care Organization (ACO)?

- An ACO is a network of providers that agrees to be held accountable for the cost and quality of care for a defined patient population
- If the cost of care for the patient population ends up being less than would have otherwise been expected, and quality targets are met, providers keep a share of the cost savings
- Cost savings are an incentive for providers to cooperate and reduce health care spending
  - e.g., by avoiding unnecessary tests and procedures and preventing duplication of care

What are the goals of ACOs?

- Health care that is:
  - Low cost
  - High quality
- Providers that:
  - Coordinate well
  - Communicate well
- Improved health of the greater community

Idealized model

What are the risks of ACOs?

- Reduction in cost by limiting or rationing care
  - A provider might not order an expensive test that is medically necessary
  - A provider might "cherry pick" patients, including
    - Choosing healthier patients
    - Refusing to accept patients with expensive health conditions
- Increased consolidation of hospitals and practices
  - Fewer independent doctors and hospitals
  - Reduced competition
    - This can drive up costs

ACOs in the United States

- > 400 ACOs are currently operating
  - 23 are part of the Pioneer ACO Program
    - Early Medicare ACO program designed for organizations already experienced in coordinating care across care settings
  - 220 are part of the Medicare Shared Savings Program
    - Created by the ACA
  - Over 160 are private/commercial programs
- Medicare ACOs cover about 4 million beneficiaries
  - 3.2 million are under the MSSP

Vermont Legal Aid
Working for Justice

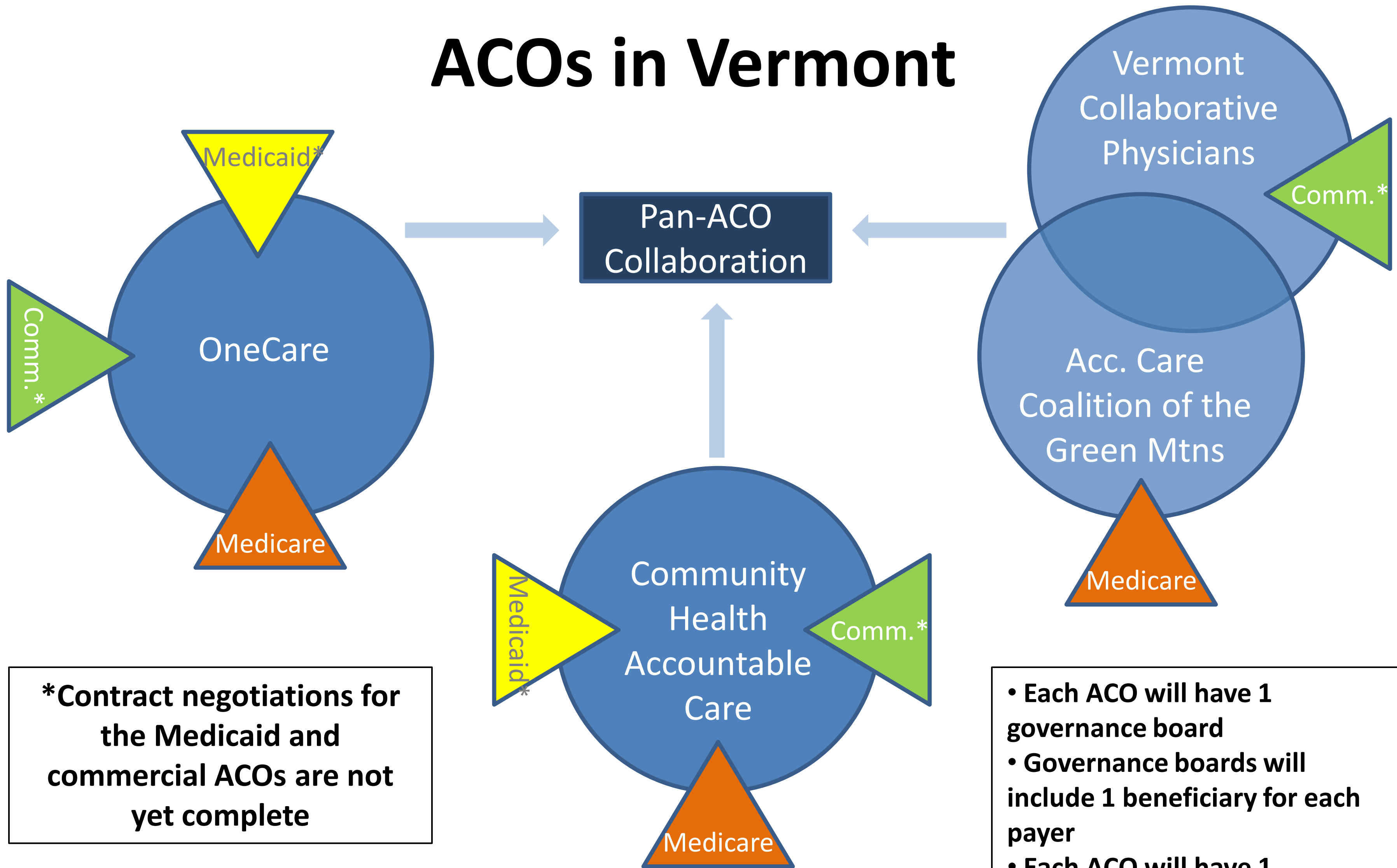
ACOs in the United States

- Transition to ACO model is happening rapidly
  - 123 new ACOs signed on to the MSSP in Jan 2014
  - The State Innovation Model (SIM) grant program is facilitating the creation of Medicaid and commercial payer ACOs, as well as other models of payment reform
  - 6 states have Model Testing Awards
    - AR, ME, MA, MN, OR, VT
  - 3 states have Model Pre-Testing Awards
    - CO, NY, WA
  - 16 states have Model Design Awards
    - CA, CT, DE, HI, ID, IL, IO, MD, MI, NH, OH, PA, RI, TN, TX, UT

ACOs in Vermont

- Medicare – 3 ACOs operating under the MSSP
  - Accountable Care Coalition of the Green Mountains – started Jul 2012
  - OneCare Vermont – started Jan 2013
  - Community Health Accountable Care – started Jan 2014
- Medicaid – ACOs in contracting process
  - Developed under the SIM grant
  - Expected start Jan 2014 (retroactive)
- Commercial – ACOs in contracting process
  - Developed under the SIM grant
  - Expected start Jan 2014 (retroactive)

ACOs in Vermont



*Contract negotiations for the Medicaid and commercial ACOs are not yet complete

- Each ACO will have 1 governance board
- Governance boards will include 1 beneficiary for each payer
- Each ACO will have 1 community advisory board

Vermont Legal Aid
Working for Justice

What are the goals of ACOs?

- Health care that is:
  - Low cost
  - High quality
- Providers that:
  - Coordinate well
  - Communicate well

Idealized model

- Improved health of the greater community

Vermont Legal Aid
Working for Justice

What is the evidence behind the ACO model?

- Can ACOs reduce costs?
  - Early results are mixed
    - 47% of MSSP ACOs saved money in year 1
    - 25% of MSSP ACOs earned shared savings
- Can ACOs improve quality of care?
  - Quality information has not been released for the MSSP
    - Year 1 of the MSSP did not include quality targets, only reporting
    - 96% of MSSP ACOs “satisfactorily reported” quality measures in year 1

*****Note:** 2 MSSP ACOs that saved money did not receive shared savings because of failure to satisfactorily report quality measures

Vermont Legal Aid
Working for Justice

What is the evidence behind the ACO model?

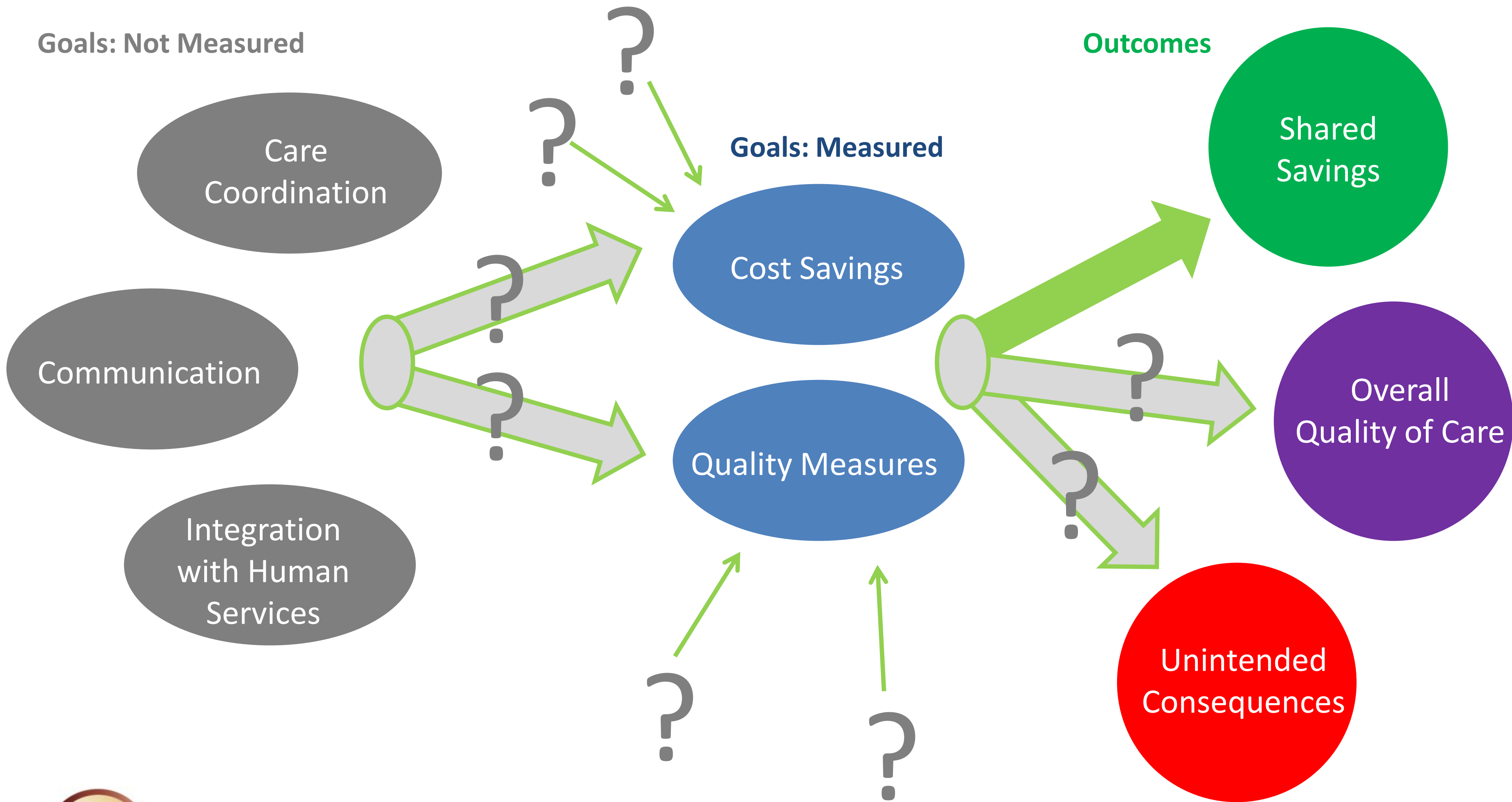
- Can an ACO improve care coordination and communication between providers?
  - Anecdotal evidence only
- Can an ACO improve the health of populations?
  - No evidence to date

For more information on the available data on ACOs, our policy paper *ACOs: What is the Evidence?* is available at: www.vtlawhelp.org/health-care-policy

What are our concerns?

- ACOs are an experimental model
- Limited oversight of quality of care
- How will care models be selected?
- How will care models integrate with human services models?
- Monitoring of the “pan-ACO” collaboration
- Consumer input during the planning process
- Governance and community engagement

Concern: ACOs are an experimental model



Concern: Limited oversight of quality of care

- Medicare Shared Savings Program
  - Measures and benchmarks determined by CMS
- Medicaid and commercial ACOs
  - Measures and benchmarks determined by work group process
  - Too few measures – no complete picture of care
    - Medicaid ACOs: 8 payment measures
    - Commercial ACOs: 7 payment measures
    - Measures selected for "areas of improvement" only
    - Insufficient measures to ensure that overall quality of care is maintained
    - Limited measure sets increase the chance of unintended consequences
  - Bar is too low
    - Under "gate and ladder" methodology, ACOs can earn points toward shared savings by achieving the national 25th percentile on a given measure
    - ACOs that don't meet minimum quality benchmarks (the "gate") can be awarded shared savings at the discretion of the GMCB
      - This language was passed by the GMCB, not via the work group process

Concern: Limited oversight of quality of care

Year 1 Payment Measures:

Medicaid ACOs	Commercial ACOs
All-Cause Readmission	All-Cause Readmission
Adolescent Well-Care Visits	Adolescent Well-Care Visits
Follow-Up After Hospitalization for Mental Illness (7-day)	Follow-Up After Hospitalization for Mental Illness (7-day)
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis	Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis
Chlamydia Screening in Women	Chlamydia Screening in Women
Cholesterol Management for Patients with Cardiovascular Disease (LDL Screening)	Cholesterol Management for Patients with Cardiovascular Disease (LDL Screening)
Developmental Screening in First 3 Years of Life	-

Concern: How will care models be selected?

- Care Models work group is beginning to look at different models
- Practices/hospitals are beginning to implement their own models
- The one concrete care model that previously came out of the work group process is not being implemented (Duals Demonstration)
  - How will care for this high-need population be managed without the Duals Demonstration?

Concern: How will medical care models integrate with human services models?

- This concern has been voiced by the disability community
- Solution has not been made clear in the work group process
- Decision not to implement the Duals Demo sent the message that there is insufficient capacity to handle this issue

Concern: Consumer input during the planning process

- SIM work groups have had minimal consumer involvement, with the exception of HCA staff
- Work groups are heavily weighted toward providers, administrators, and state employees
- Decisions are made by majority vote at each level, consumer advocates are either in the minority or absent at every level
- Information provided to the public is minimal
  - The SIM website does not include up to date information about the activities of the work groups
    - A new website was supposed to be launched in January but has not been
  - Work group, Steering Committee, and Core Team meetings are noticed only via the Department of Libraries website

Concern: Governance and community engagement

- ACOs are being implemented using a top-down approach
- To our knowledge, there has been minimal community or consumer involvement to date
- This is not an organic community based approach
- Reinvesting shared savings to improve population health is not part of the model
- Going forward:
  - ACO governance boards are supposed to include one beneficiary for each payer, which was advocated for by the HCA
  - ACOs will implement consumer advisory boards beginning in 2014, which was advocated for by the HCA

Concern: Monitoring of the “pan-ACO” collaboration

- Pan-ACO Collaboration
  - The three ACOs have formed a collaboration called the “pan-ACO”
  - Collaboration can be good for care coordination, but there are risks
  - Pan-ACO is working on HIT issues, unclear what else
  - GMCB has been monitoring
  - Continued close monitoring is essential to ensure that collaborative activities are appropriate

How has the HCA been involved?

- Active participation and consumer advocacy in SIM Steering Committee
- Active participation and consumer advocacy in SIM Work Groups:
  - Payment Models
  - Quality and Performance Measures
  - Care Models & Care Management
  - Disability and Long Term Care (formerly Duals Demonstration)
  - Population Health
- Regular attendance and public comment at SIM Core Team meetings
- Regular attendance and public comment at GMCB meetings
- Written comments to SIM Work Groups, SIM Steering Committee, SIM Core Team, the Green Mountain Care Board, and the Agency of Administration on topics including:
  - ACO measure sets and gate & ladder methodology
  - ACO consumer engagement requirements
  - Recommendations for ACO notices
  - Consent policy for the Vermont Health Information Exchange (VHIE) with VITL

How has the HCA been involved?

- At each level in the work group process, HCA staff voiced concerns
- Because of the structure of these groups, most of our concerns were not addressed, including:
  - The number of measures
  - The low bar for the gate and ladder methodology
  - The governance structure
- Some of our successes include:
  - Inclusion of beneficiaries on the ACO governing boards
  - Requirement to have community advisory boards

➢ Often the HCA has been the only consumer advocate involved

Questions?

Trinka Kerr, Chief Health Care Advocate

tkerr@vtlegalaid.org

Julia Shaw, Health Care Policy Analyst

jshaw@vtlegalaid.org

Office of Health Care Advocate

Vermont Legal Aid

www.vtlawhelp.org/health

1-800-917-7787

Vermont Legal Aid
Working for Justice