Accountable Care Organizations

What's Next?

Challenges and Opportunities for Primary Care

Wells Shoemaker MD, Medical Director
California Association of Medical Groups

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Messages Part 1

1. CA has been doing large scale "ACO pilots" for 15-20 years → many tests of concept in many settings. Successes and disappointments

2. **It works.** For both Quality and Affordability… for large populations and diverse regions.
   - Locally organized, clinically motivated, technologically sophisticated, administratively competent, fiscally responsible systems
   - Some limitations and some variability

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Messages Part 2

3. Complex payment methodology, including cap, supports centralized coordinated care infrastructure *and* affordable premiums
4. Administrative sophistication is essential for network relationships, care management, finance, & sustainable innovation
5. It's coming, thanks to reform bill

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CAPG

- 150+ Medical Groups in CA
- 13 Million people in HMO delegated model +5-6 M in FFS = 18 Million +/-
- Both private and public sector care
- Trade assoc interests: Lobby & Business
- Push for QI, consistency, affordability
- Collaborator Culture for QI & EBM
- Measurement & performance "culture"

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Philosophical Basis: Group View

- Community-wide systems are foundation for effective care of populations—not small offices
- Group provides critical infrastructure support for connected, Advanced Medical Homes—with accountable "team play" in return
- Save money by supporting timely "right" care …not by avoiding risk or obstructing care
- Pts are "ours" long term—not remote Plans'
- Respect administrative competence
- Culture of accountability—Quality and Finance

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Quick History of the ACO

- New acronym 2009
- Specified in reform law March, 2010
- Strong appeal from New England brain trust—Dartmouth, Brookings, Fisher, McClellan, NEJM, IHI & Berwick—year long dialogue → influenced CMS policy
- Early interest by organizations across US
- Recognition of CA group model & risk

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Accountable Care Organizations

Three principles of the ACO mantra:

1. Local organization and accountability
2. Standardized performance measures
3. Payment reform

From Brookings Institute ACO Learning Collaborative Sept, 2009

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ACO's—Likely Attributes

- Network offers full continuum of care
- Sufficient size and IT horsepower to measure, connect, apply
- Sufficient administrative capacity (and reserves) to manage complex payment mechanisms
- Medicare & Medicaid by law…likely will expand to commercial…hazy now

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Reform Act Provisions

- HHS designs shared savings model
- Create legal framework for shared dollars
- Wide range of potential qualifying orgs
- Priority to those already "up"
- Medicaid—allow peds groups to be ACO's
- Start date: January, 2012

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Three Tiers Likely

1. Simple gainsharing, largely FFS, for early development groups
2. Expanded opportunity for gainsharing, some partial cap/bundled payments. No downside risk. More sophisticated orgs.
3. Meaningful risk, larger cap %, larger potential share of savings. (CA is here)

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What that really means...

- Hospitals will have to get back into the collaboration business (NATO analogy)
- Capitation (by another name) is back
- Lone Wolf Docs may be compelled to become joiners...*and they will howl*
- Apportioning dollars will create friction for decades (nothing new to us...)

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Speak to me in Californian

- We should be well ahead of the rest
- But we have a lot of work to do
  - Hospital buy-in and role
  - Public and private sector overlap
  - Rural vs Urban
  - Primary care workforce...more later on that!
- Remember: Affordability is key promise
- Quality alone is not enough.

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Where do Community Health Centers & FQHC's fit?

- Language is not prescriptive.
- Generally speaking, these organizations do not offer full spectrum of services, admin structures for complex payment schemes, nor compact with non-clinic providers
- Essential to be included in ACO; less likely to be "anchor" structure. *Think COHS.*
- Geographic experiments will emerge

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Will ACO's be good for PCP's?

- Should be much better than now
- Opportunity for better central support
- Opportunity for payment for currently unreimbursable services, esp care coordination & communication
- Opportunity for greater income—based on performance, not volume
- Greater responsibility—no "islands"

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Crucial Test for the Future PCP

- Will participation enable a physician to practice in a prideful, collegial fashion, concentrating upon the features that attracted him or her to medicine in the first place, in a financially sustainable manner?
- CA group experience would say Yes, but…
- …not automatic.

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Wells' Petrushka Doll concept: "Home, Neighborhood, City"

- High functioning Medical Homes, inside…
- Accountable, administratively capable group with population focus ("medical neighborhood"), inside…
- ACO…"municipal utilities"…fire, police, roads, education

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Cross over Medical Home and the "Medical Neighborhood"

- Electronic tools for both individual and population care—not achievable as one-off
- Measurement, feedback, improvement
- Connectivity with specialists & teams
- Pay for outcomes, not volume *(not yet…)*
- Incentives to welcome complex care
- Cost consciousness …and…

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More patient service features…

- Help patients navigate complex systems
- Accessible, respects need for convenience
- Openness to divergent views
- Informed choices versus "command"
- Language and cultural engagement

- Can't really do that without system

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ACO's Must Improve PCP "Life"

- Income boost—parity with England
- Respect intelligence and role
- Personal growth, health, family
- Support for clinical excellence, not just new avalanche of paper scutwork
- *Easier said than done*
- *And we're way behind*

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Under the Hood

Going Under the Hood—CA Group Infrastructure Today

- Medical Home as a system trait—formal linkage, contractual responsibilities
- Health IT "Central intelligence"—point of care, connectivity, care coordination, population care
- Evidence-based decisions: local, ethical, MD led (more than "UM"—communication intensity)
- Formal QI programs and staffing
- Network relationships—more than money—coherent approach to quality, accountability

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Administration Under the Hood

- Grasp of utilization and quality measures
  - Claims based + other capture
  - Identify problems and priorities
- Sophisticated payment methods to providers: Capitation, FFS, hybrids, shared savings, P4P….
- Relationships with multiple payors, all different
- Relationships with hundreds of doctors, all different
- Fiscal responsibility, SB 260 solvency

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Still Under the Hood

- Measurement-based feedback, performance incentives, P4P plus local enhancements
- Formal physician leadership roles, with ongoing training & professional development
- Acceptance of standardization (P4P, ICE)
- Legal compliance, contractual obligations—CA legislature is a prolific body! DMHC powerful
- Collaborative relationships for learning & exchange—CAPG, IHA, CQC, others

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Challenges we faced pre ACO… Likely to stay with us a while

- Primary care workforce shrinkage
- Trust between parties—govt, insurors, groups, hospitals, medical associations, employer/purchasers, advocacy groups
- Misaligned incentives will persist
- Geographic variability in behavior and resources
- Capital for systems development
- Takeways will not be peaceful

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2010 - 2015

- Should be a golden age of creative thinking and rapid communication
- Tolerance and expectation for disruption in pursuit of greater good—accommodate "great leap" system improvements
- Diplomacy at local, state, federal levels
- Some "Tough Love" and friction coming, too

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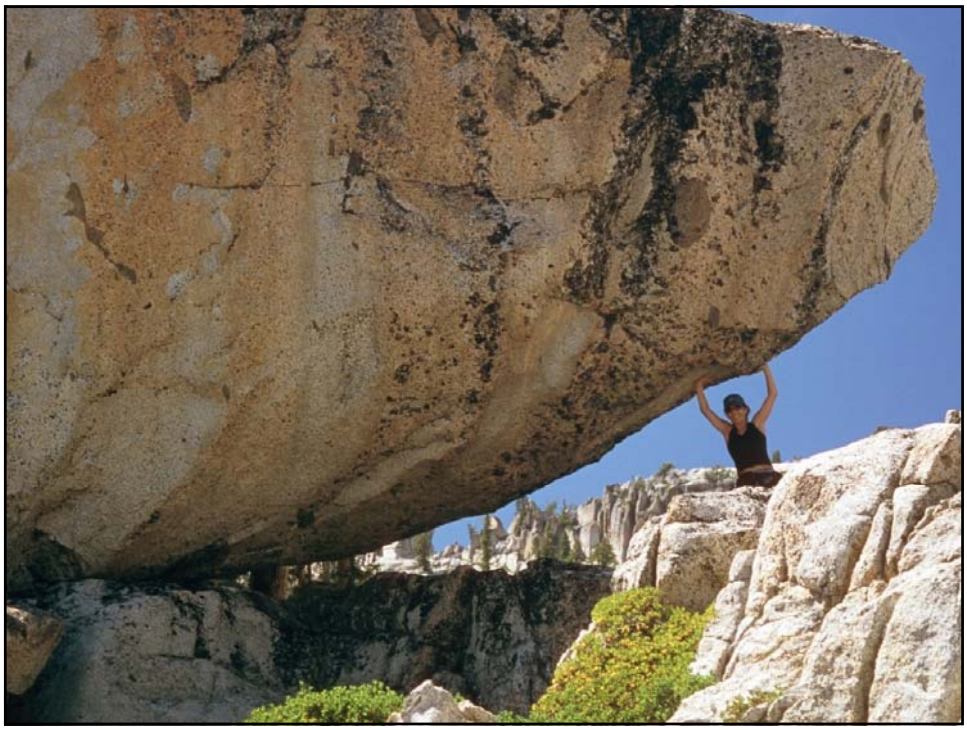
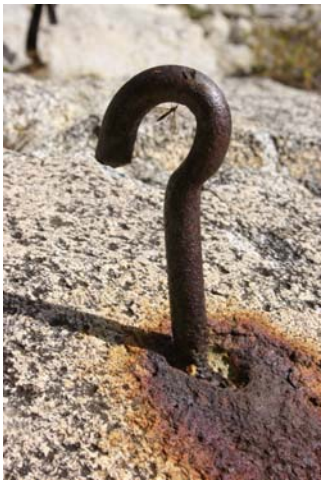


Questions?



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Contact Information

Wells Shoemaker MD
wshoemaker@capg.org

www.capg.org
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