HEALTH SECTOR ADVISORY COUNCIL MEETING

ACCOUNTABLE CARE ORGANIZATIONS & PAYMENT REFORM

PRESENTATIONS AND DISCUSSIONS WITH
COUNCIL MEMBERS AND STAKEHOLDERS

29 April 2011
The Fuqua School of Business, Durham, NC

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Table of Contents

Context

This meeting of the Duke University Health Sector Advisory Council, held at Duke University on April 29, 2011, brought together a group of senior health care experts, including leaders of health care provider organizations, health economists and academic experts in management and strategy. The purpose of the meeting was to discuss the accountable care organization (ACO) concept and the proposed CMS regulations dated March 31, 2011. In doing so, the group was able to provide useful and actionable comments on the Draft ACO Strategy to CMS during the comment period.

Key Themes

- Given the current fiscal reality of the Medicare program, it is clear that something must be done to control health care costs. While healthcare reform was mainly coverage legislation, the ACO concept was a first step in trying to change the delivery system in order to control costs.
- While the concept of ACO's held some promise when initially described in the Patient Protection and Affordable Care Act (PPACA), participants at the Health Sector Advisory Council meeting had a lot of complaints regarding the specific regulations that were added by CMS.
- The modest incentives in the ACO program are unlikely to compel a large number of organizations to undertake the large investment necessary to become an ACO.
- Other issues with the specific ACO regulations include the short timeframe of the program, the number of quality measures, the retrospective assignment, and the 2% threshold, among others.
- Participants concluded the meeting by suggesting additional ways of achieving cost containment: moving away from fee-for-service (FFS) payments; changing reimbursement of hospital readmissions; using an evidence based approach to care delivery; focusing on reducing costs for end of life and hospice care; and, increasing consumer engagement and involvement in their health care spending.

ACO Definitions, New Regulations – An Overview and Comments

Presenters: **Stuart Altman, Ph.D.**, Professor of National Health Policy, The Heller School for Social Policy & Management, Brandeis University
Aaron McKethan, **Ph.D.,** National Program Director, Beacon Communities Program, Office of the National Coordinator for Health IT, CMS

Context

Given the current fiscal reality of the Medicare program, it is clear that something must be done to control healthcare costs. There are essentially three options for the government to control healthcare costs: i) rate regulation, ii) rationing of care, and iii) changing the delivery system. In order to avoid rate regulation and rationing of care, the government must attempt to change the current payment and delivery systems in order to generate efficiencies and improve quality at the same time that it lowers cost. It must do this through a redesigned health care delivery system that rewards higher quality and lower costs. This is where the idea of an ACO originated. ACO's take up only about seven pages in the Patient Protection and Affordable Care Act (PPACA), yet they have become one of the most talked about provisions. While a hot topic, there is still much confusion over what an ACO actually is. This session attempted to define just that. Most simply stated, an ACO is a network of doctors and hospitals that shares responsibility for providing care to patients.

Key Learnings

ACO's were designed to avoid the main problems of the HMO debacle of the 1990's.

Two lessons were learned from HMO's in the 1990's that had a direct impact on the creation of ACO's. With HMO's, healthcare delivery systems were asked to take on risk and to manage a population of patients, but they lacked expertise in managing risk and they lacked the data to understand the populations they were serving. Thus, with ACO's, providers will not be required to assume risk as an ACO is a "shared savings system" and each ACO will start from their current level of spending. The second lesson came from the backlash from patients over being locked into a delivery system. Thus, with ACO's, patients will not be locked into a delivery system; they will sign up with a PCP but can change their PCP or network with no penalty.

The law allows for many different groups to become an ACO.

The law allows for all different groups to become an ACO, including physician group practices, networks of individual physicians, hospital-physician joint ventures, hospitals with employed physicians and other providers or suppliers. However, Altman believes ACO's are focused on physician practices and small and medium sized hospitals and are a direct attack on academic medical centers where more expensive care (due to the latest technologies being used) is likely to be found. Beneficiaries will be assigned to an ACO retrospectively; assignment will be based on where they got the plurality of their primary care from a participating primary care doctor over the last year. A primary care doctor is defined as general practice, family practice, internal medicine, and geriatric physicians. This poses a potential challenge since many sick Americans receive their "primary care" from a specialist physician.

An ACO's benchmarks are based on national trends.

Benchmarks will be defined from the provision of beneficiary data from those who would have been eligible in the last three years. The benchmark will be determined by per capita Part A and Part B (Part D is not included) expenditures in the previous three years (weighted 60% in Year 3, 30% in Year 2, and 10% in Year 1) for ACO eligible beneficiaries. Beneficiaries will be adjusted for complexity of disability. The benchmark will be trended forward for the three-year performance period. The national growth rate (as a %) will be used to move from the benchmark period to the beginning of the shared

savings period for the first year. After the first year, the benchmark will be based on growth in *absolute* amount of national A&B spending.

An ACO initially has two choices – a 1-sided and 2-sided risk model.

In the 1-sided model, if an ACO's spending falls below the benchmark, the ACO gets to share in some of the savings. If the ACO's spending is above the benchmark, there is no consequence. The ACO and the government will share savings 50/50 under the 1-sided model. In the 2-sided model, the ACO gains if it beats the benchmark but loses if it misses the benchmark. The ACO and the government will share savings 60/40 under the 2-sided model. An ACO will be able to choose the 1-sided model for Years 1 and 2 but must select the 2-sided model for the third year. Under either model, ACO providers will continue to receive FFS payment. An ACO must achieve a "minimum savings rate" before becoming eligible for payment – this is based on a statistical threshold based on size under the 1-sided model and a 2% threshold under the 2-sided model.

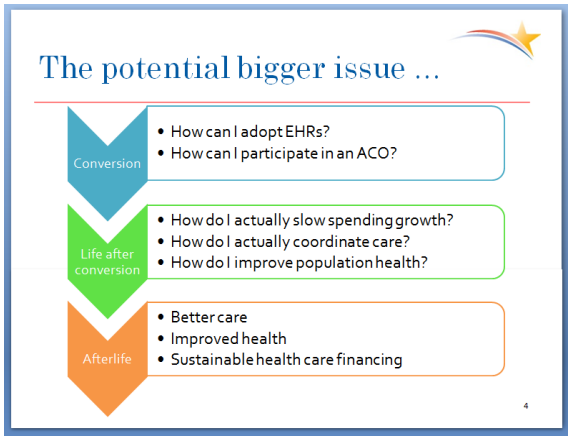
Shared savings payments are contingent on quality performance.

There are 65 quality measures in the ACO regulations. In year 1, only reporting is required. In subsequent years, ACO's must meet minimum thresholds equal to the 30th percentile (comparison group could be FFS, Medicare Advantage or ACO depending on the measure). CMS proposed a "sliding scale" above the 30th percentile to determine a final savings share.

The modest incentives of the ACO program may not be enough to warrant the very large investment.

The costs necessary to become an ACO are quite large, about $2 million in upfront costs including investments in people, skill development, and healthcare IT. On the other hand, the benefits to becoming an ACO are modest at best. There is general concern that the shared savings percentage (50-60%) is too low and that the savings must exceed the 2% threshold before benefitting the ACO. Until the FFS system becomes much less generous, it is likely that many organizations will not find ACO's attractive enough to invest in becoming one.

While controlling Medicare spending is important, the bigger issue may be how we achieve an "afterlife" of lower spending growth and improved outcomes.



"Market Power" and Other Selected Issues Re: ACO's

Presenters: **Robert Berenson, M.D.**, Institute Fellow, Urban Institute; Vice Chair, Medicare Payment Advisory Commission (MedPAC)
Kevin Schulman, M.D., M.B.A., Professor of Medicine and Gregory Mario and Jeremy Mario Professor of Business Administration, Duke University; Associate Director, Duke Clinical Research Institute

Context

Given the cost of becoming an ACO, many organizations may determine it is not worth it to make the required investment. Organizations that do become ACO's may do so not for the cost savings to be shared with Medicare beneficiaries but to strengthen their market power over purchasers in the private sector. Through consolidation, organizations can increase their provider market power. Although the ACO regulations appear designed to achieve savings through vertical integration, they inevitably invite horizontal integration as well. This is potentially problematic if healthcare organizations use their market power to extract higher prices from private health plans. While the government's goal may be to reduce Medicare costs, an unintended consequence may be increased costs for private plans.

Key Learnings

Two potential problems in the regulations are the timeframe and the program structure.

The ACO regulations only provide a 3-year timeframe. This is likely not long enough for organizations to realize savings at the magnitude necessary to warrant the large investment. Berenson suggests a 5 or even 10-year commitment from Medicare (after a demo period). Further, ACO's were set up as a program rather than a demo. This means that CMS lacks control over who can participate initially. However, ACO's may end up looking like a demo if very few organizations choose to participate. There is fear that if these initial ACO's fail, it will take many years before something similar could be introduced.

The number of quality measures is overly burdensome.

There are at least 65 measures (potentially more with composite measures) in the ACO regulations. The burden on an organization to produce data for all of these measures may be restrictively high. Only 11 of the measures are based on claims data where new data does not need to be generated. The vast majority of the measures will need to be produced, and small organizations may not have the resources to do this. The only organizations that might consider doing this would be large hospital organizations that might have other reasons for making such a large investment (i.e., increasing their market power in the private sector). Further, even if organizations can produce data for all of these measures, it remains unclear how the government will monitor that the ACO is using these measures to improve efficiencies.

Changing incentives will not change behavior if the incentives aren't large enough.

Schulman argues that changing incentives will not change behavior when the behavior is based on millions of dollars of infrastructure investment. He points out that the savings is likely to be only a decimal point in the P&L of the organization. Firms cannot significantly change without restructuring and restructuring is really hard to do. The trivial incentives that an ACO provides (that go away in just 3 years) will not be enough to get organizations to change their behaviors.

Reducing transaction costs is a painless way to reduce health care costs.

Everyone can agree that we need to reduce healthcare costs. The goal of ACO's is to reduce costs to

Medicare. But, we also need to reduce healthcare costs in the private market. It is worth examining what the specific costs are. There is the cost of individual units of service that may or may not be necessary. There is variation in the price of units of service at different sites of care. There are also some costs that don't need to reduce procedures to achieve savings, such as transaction costs. Reducing non-value-added costs such as transaction costs is an area that everyone can agree upon.

Payer and Provider Perspectives on ACO's and Payment Reform (Part 1)

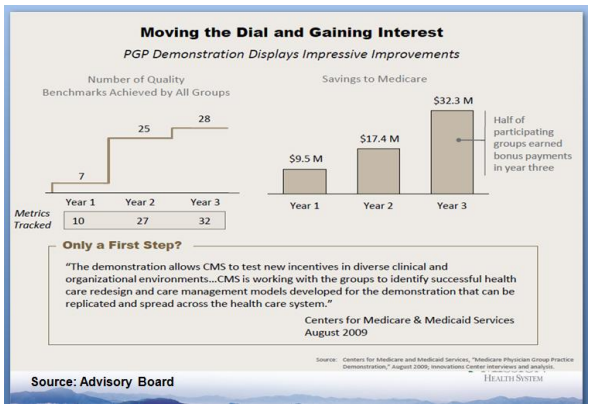
Presenters: **Ronald Paulus, M.D., M.B.A.,** President and CEO, Mission Health System

Context

Ron Paulus led the physician group practice (PGP) demonstration at Geisinger Health System. The PGP demo, a Medicare value-based purchasing initiative, initially ran from 2005 to 2010 and tested the idea that accountability at the practice level would allow Medicare to identify the population of beneficiaries being served, measure cost savings and quality improvement for this group, and share a portion of the savings if the practice were able to achieve a certain threshold of savings and quality performance. The PGP demo had some key learnings; unfortunately, few made it into the ACO regulations.

Key Learnings

While the PGP demo achieved improvements in quality as well as savings to the Medicare program, the majority of groups did not make enough money to cover the operating costs of the demo.



Although improvements in quality were made and savings to Medicare were achieved, only 5 of the 10 groups ever made any money, and of those, at least 3 of the 5 didn't make enough money to cover the operating costs of the demo. The one group that did really well did so because it doesn't have a hospital. If there is a hospital in the system, the system will need to make back the cannibalization because the savings come almost exclusively from keeping people out of the hospital. Furthermore, the programs chosen to participate in the PGP demo were the programs most likely to do well, and even so, they didn't end up doing *that* well. Many of the organizations already had a downward trend in costs; thus, much of the continued trend may have been achieved with or without the incentives of the PGP demo.

Given the limited upside in an ACO, an organization might choose to create a Medicare Advantage plan instead.

If a hospital is involved, the organization needs to make up the costs of implementation as well as the cannibalization of the hospital, and even then, it only stands to achieve 50-60% of the savings. Given the limited upside, why would an organization go through all the trouble when it could opt to create a Medicare Advantage plan instead and receive 100% of the achieved savings? While the intent of the ACO program is sound, the incentives seem to be too small to warrant behavioral change.

One alternative to ACO's with respect to lowering costs in the system is to change the way Medicare pays for readmissions to the hospital.

Paulus asserts that a more effective way to lower costs would be to change the way readmissions are reimbursed. Medicare could give hospitals the opportunity to win by taking their readmission rates down by 5-10% each year, eventually getting the hospital down to a level deemed appropriate. Paulus believes this strategy would have fewer unintended consequences than the ACO program.

Payer and Provider Perspectives on ACO's and Payment Reform (Part 2)

Presenters: **David Cannady, M.H.A.,** Vice President, Strategic Resource Group, HCA

Context

David Cannady is the Vice President of the Strategic Resource Group at Nashville, Tennessee-based, HCA, the nation's largest non-governmental health care delivery system. This session discusses how HCA is thinking about reform and the ACO regulations. HCA is typically #1 or #2 in its markets, with market share ranging from approximately 20-40%. HCA thinks about healthcare as a local delivery system and is a portfolio manager in this respect; HCA makes all decisions on the local level. With regards to various payers, commercial payers are subsidizing the rest of the business, making up the largest percentage of HCA's net revenues.

Key Learnings

HCA's strategy is to "operate in the present while preparing for the future."

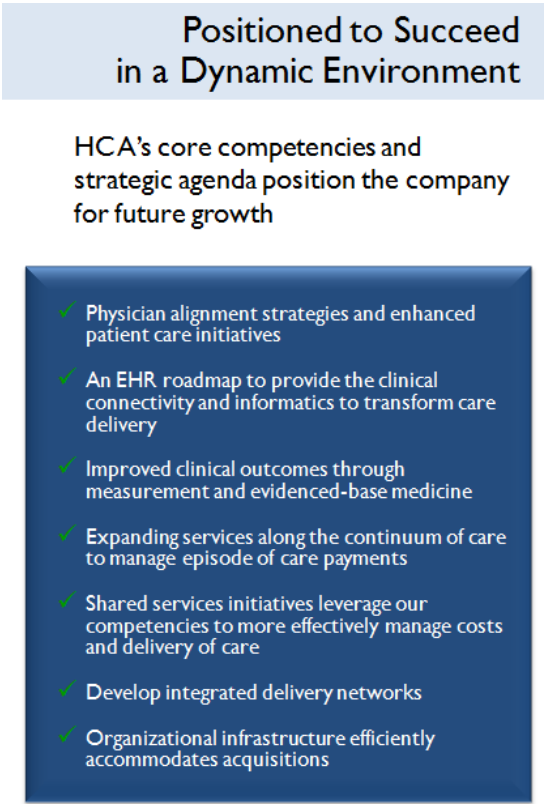
HCA believes they need to make investments for the future, but they don't believe the business model is actually changing very rapidly. Thus, part of their strategy is to continue to make money in the current model and avoid hurting today's revenue stream. HCA believes that the timing of segment change will vary depending upon the amount of regulation and managed care maturity of each market. Thus, providers like HCA will need to have an operating strategy that works in a variety of environments and that can adjust as a market or segment changes.

The challenge to HCA lies in adapting capabilities to the evolving market, including widely divergent segments, while reducing overall cost of care.

As HCA thinks about ACO's, they consider many capabilities that they will need to create or adapt. This includes electronic health records and being able to mine and manage that data. Further, being able to have a single order set that works in multiple markets would be a big achievement. Creating more coordination among hospitals would also be a big achievement; however, some hospitals within HCA actually compete with each other. Other areas include a retail/consumer orientation, pricing and cost management, and reimbursement. Reimbursement is one of the most challenging capabilities as there are many different payment systems.

Overall, HCA believes they are positioned to succeed in this dynamic environment.

HCA believes that market driven "reform" is actively underway regardless of the pace and scope of legislative reforms. Whether market driven or legislative reform, HCA is well positioned given its size and scale, insights into clinical care, efficient providers, and ability to make strategic acquisitions.



Implementation and Data Challenges for ACO's

Presenters: **Kristine Martin Anderson, M.B.A.,** Senior Vice President, Booz Allen Hamilton
Tom Tsang, M.D., M.P.H., Medical Director, Meaningful Use, Office of the National Coordinator for Health Information Technology, HHS

Context

"Meaningful use" refers to the use of a certified electronic health record (EHR) in a meaningful manner, such as e-prescribing; the use of certified EHR technology for electronic exchange to improve quality of health care; and, the use of certified EHR technology to submit clinical quality and other measures. There is significant overlap in the goals of Meaningful Use (MU) and the proposed ACO rule, including the requirement that 50% of PCP's of ACO's need to be meaningful users by the second year of the ACO contract, extensive overlap between clinical quality measures, and the ACO regulations call for patient access to both medical records and evidence-based data, enabling informed patient decision-making.

Key Learnings

It will take a great deal of sophisticated infrastructure to successfully run a risk-bearing ACO.

ACO's will need to integrate information across multiple organizations. They will need to tie financial systems to clinical systems and understand the costs and where the savings are coming from. They will need patient engagement and involvement. Many organizations are functioning successfully in today's environment without undergoing this huge investment. For organizations that do make the investment, there is a potential for significantly more losers than winners, particularly given the short length of the contracts (3 years).

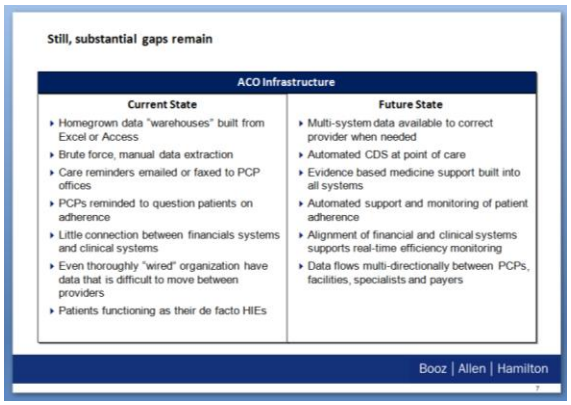
Even with EHR, the extraction and reporting of quality data is labor intensive and challenging.

CMS did not fully appreciate the intensity of reporting on 65 quality measures. It is time consuming and challenging to integrate and work with claims and clinical data. The systems were built to put data in, not to easily extract data, making the reporting of 65 measures difficult. Typically, each entity within an organization has its own IT, complicating the reporting of measures for the entire system.

In addition to quality measures, additional ACO infrastructure requirements may prove burdensome.

ACO's must notify beneficiaries of their participation in an ACO and the ACO's potential to receive additional compensation. Further, they must notify beneficiaries that their data may be shared, and they must accommodate beneficiaries' desire to opt out of data sharing. In Anderson's experience, these notifications and keeping track of responses is difficult and will induce additional costs.

There is evidence of increasing sophistication, but substantial gaps remain between current state and future state.



Potential winners include technology companies that can tie entities together with limited capital.

Any organization with a reputation for quality and efficiency will likely be sought out to join or serve an ACO. Nimble organizations that can respond quickly to changing market dynamics will also do well in this environment. Technology companies that can tie organizations together, especially those with low

capital requirements, are in an especially favorable position. Early results suggest that large, integrated organizations with solid infrastructure, scale and access to capital appear to have a tremendous advantage, but are also likely to be at a cost disadvantage.

In terms of infrastructure requirements, hospitals become the natural leaders of ACO's.

Hospitals' access to capital and management expertise make them the natural leaders of ACO's in terms of infrastructure requirements. However, as cost centers, hospitals are not the obvious choice of leader in an ACO. This is because if ACO's function as envisioned, total hospital days are likely to fall, readmission rates will fall, and a reduction in emergency department visits will reduce admissions. Of note, there is an interesting advantage to community hospitals, who finally have a business case for not referring all patients to (higher cost) specialty facilities.

Advanced data analytics could identify modifiable behaviors.

Through the use of advanced data analytics, organizations could potentially identify, manage and decrease risk pools. Identifying modifiable behaviors could be key to reducing risk. Another goal of advanced data analytics is to create seamless patient transitions and increase coordination of care. Lastly, medication adverse events could be prevented through the use of advanced data analytics.

Innovative Supplier's Perspective on ACO's

Presenters: **Parashar Patel,** Vice President, Global Health Economics & Reimbursement, Boston Scientific Corporation

Context

Boston Scientific is a worldwide developer, manufacturer and marketer of medical devices that are used in a broad range of interventional medical specialties. With over $8 billion in revenues and a portfolio of more than 13,000 products, Boston Scientific is dedicated to improving the quality of patient care and the productivity of healthcare delivery through the development of less-invasive medical devices and procedures. This session provides Boston Scientific's perspective on ACO's based on their portfolio of products. Patel notes that it is unclear what the role of an implantable medical device company is with regard to ACO's, but that hospital customers have already begun asking Boston Scientific to be a partner in forming ACO's.

Key Learnings

One challenge for a medical device company is that hospitals will want to "partner" with them on price.

Given that ACO's are a shared savings program, one of the first areas hospitals will look to lower costs will be with their suppliers, including medical device companies such as Boston Scientific. However, cutting prices alone, if achievable, will not be sufficient or sustainable.

A second challenge for a medical device company is to be relevant with regard to the 65 measures.

As stated earlier, there are 65 measures required for ACO's. Of the 65 measures, most are patient satisfaction measures versus true outcome measures. None of the measures are directly related to any of Boston Scientific's devices. For example, there is no measure that would look at the results from a stent that is put into a patient. Currently, there are no direct measures of device or physician performance. Another challenge is the length of time that you measure savings. When analyzing the savings a hospital could achieve using one therapy versus another, the 3-year timeframe may not be long enough. Patel provides an example with neurostimulators for back pain. Currently, non-rechargeable neurostimulators need to be replaced every 3 or 4 years. Boston Scientific developed rechargeable neurostimulators with a battery life of 20 years. But, a hospital won't see this savings during the ACO program length of 3 years.

Although there are challenges, Boston Scientific sees an opportunity for partnerships.

Boston Scientific sees an opportunity to partner with hospitals if they can convince hospitals of their areas of expertise. For example, Boston Scientific could provide expertise in operations management, including managing transaction costs. If Boston Scientific can create a partnership that reduces costs without cutting the prices of their medical devices, then everybody wins. Another opportunity is to expand physician training, given that better trained physicians will produce better outcomes. There may also be opportunities to use technology to improve reporting. For example, one of the ACO measures is how often you record the weight of CHF patient visits. Boston Scientific has technology that would permit more continuous monitoring of blood pressure and weight remotely that would send data directly to the physician.

Boston Scientific is taking a "watchful waiting" approach with regard to ACO's.

Boston Scientific is proactively changing its business model because of secular trends in cost reduction that will continue whether or not ACO's take off. Boston Scientific is more concerned with the ongoing consolidation between hospitals and physicians, another trend that is happening regardless of the status on ACO's. This consolidation is worrisome as it creates or increases provider monopoly power that will allow organizations to force greater price cuts from Boston Scientific and other medical device manufacturers.

Boston Scientific has identified some key questions with regards to ACO's that may affect its business.

Boston Scientific wonders whether ACO's will truly be primary-care centered as written in the regulations or if they will be more hospital-centered organizations. Furthermore, will primary care referrals to specialists and interventionalists increase or decrease? Boston Scientific markets to specialists and in many of their therapy areas, there is underutilization of services because of a lack of referrals; if they can get patients through the referral process, they can get them the procedure they need. Thus, any impact on referral patterns will affect Boston Scientific's business. Another key question is what the source of savings will be after hospitals are done beating up medical device companies on price. Care process improvements are the most difficult to implement and sustain. The last key question is what the impact will be on the supply of specialists. The growth in cardiology, GI and other specialists in clinical areas of interest to Boston Scientific are predicted to be slower than others and will not keep up with demand. The emphasis on primary care with regards to ACO's may worsen the situation. A significant downward trend in the supply of specialists could affect long-term growth for procedure-based interventions. In such an environment, technologies that increase specialists' productivity, lower infection rates, reduce length-of-stay, or lower hospital readmissions could be a competitive advantage.

All Presenter's Panel and Group Discussion

Participants: **Stuart Altman,** Professor of National Health Policy, The Heller School for Social Policy & Management, Brandeis University; **Kristine Martin Anderson,** Senior Vice President, Booz Allen Hamilton; **Robert Berenson,** Institute Fellow, Urban Institute; **David Cannady,** VP Strategic Resource Group, HCA; **Aaron McKethan,** Director, Beacon Communities, Office of the National Coordinator for Health IT, CMS; **Parashar Patel,** VP Global Health Economics & Reimbursement, Boston Scientific Corporation; **Ronald Paulus,** President and CEO of Mission Health System; **Kevin Schulman,** Professor of Medicine and Gregory Mario and Jeremy Mario Professor of Business Administration, Duke University; Associate Director, Duke Clinical Research Institute; **Tom Tsang,** Medical Director, Meaningful Use and Quality, Office of the National Coordinator for HIT, CMS

Context

All participants were asked: If ACO's are the only politically feasible solution, what are the one or two regulations (the most onerous regulations) that are most important to change during the comment period?

Key Learnings

Participants cited many issues with the ACO regulations as they currently stand.

Participants noted the following problems in the ACO regulations:

1. Retrospective assignment
2. 2% threshold
3. Data transparency and data frequency
4. Length of program
5. Too many quality measures – perhaps an organization could choose a subset of the 65 measures to report on
6. Shared savings to the organization is too low (should be higher than 50-60%)
7. Should be a demo and not a program
8. More emphasis on how the ACO's are going to restructure in order to achieve savings
9. Add some real outcome measures versus process measures

In order to achieve cost containment, more will need to be done.

Participants agreed that ACO's alone are not enough to achieve cost containment. An important point is that the health care legislation was *coverage* legislation. Thus, legislators didn't include much with respect to cost control because the bill would not have passed. However, they wanted to do something about cost containment, and thus, they included the ACO regulations.

Participants in the discussion asserted that the whole health care system needs to move away from fee for service (FFS) in order to achieve significant cost savings. As long as FFS continues to be generous, the incentives are still large for hospitals to increase volume of procedures. Changing reimbursement for readmissions was cited as another way to contain costs. Yet another area to focus on is an evidence based approach to care delivery. For example, with or without back surgery, there is no difference in patient results. End of life care and hospice care are additional areas where we can focus on reducing costs in the system. Participants also asserted that the American public is ready to make choices for health care quality versus cost. Americans have seen health care costs rise dramatically, and are beginning to understand that they can't have it all anymore.