9. CUTTING HEALTH CARE COSTS

Innovations from Pioneering Accountability in Care

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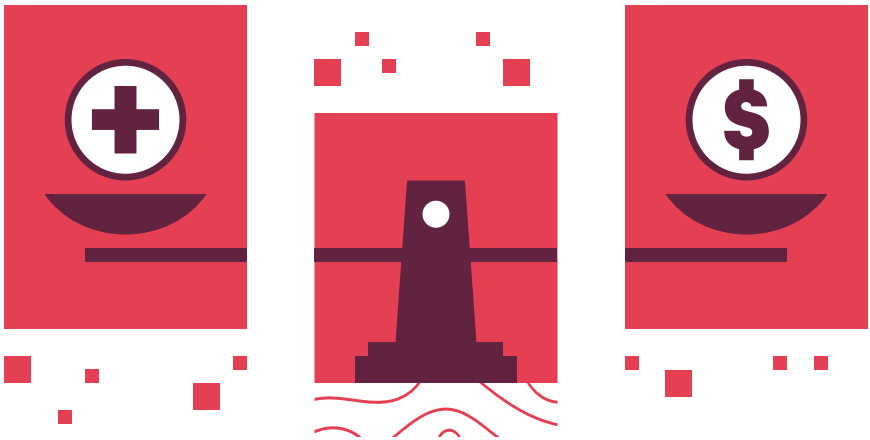

The United States has high health care costs, at least relative to other developed countries. In 2010, national spending on health care totaled $2.6 trillion, nearly 18 percent of the country's economic activity.[1] However, this spending comes without comparable gains in critical health and quality outcomes, such as life expectancy.[2]

The Patient Protection and Affordable Care Act (ACA, or Obamacare) was enacted in 2010 to address two key causes: the number of uninsured Americans and the costs of health care. The ACA included provisions to control the rise in health care spending while also improving the quality of patient care. One approach encouraged health care providers to organize activities in a way that focuses on the quality of the care delivered by taking a holistic look at the value of care. [3] This included the development of accountable care organizations (ACOs), which are groups of physicians and/or hospitals that take on the responsibility of the cost and quality of care for a patient population and move the system away from the historic fee-for-service model. ACOs are rewarded for managing chronic conditions and avoiding hospital admissions and other expensive and/or unnecessary services. The ACA established the Medicare Shared Savings Program (MSSP) as the permanent, national ACO program.

The ACA also restructured how the U.S. Department of Health and Human Services (HHS) went about testing new ways of paying for and delivering health care in order to determine which strategies were appropriate for larger-scale policy reforms. Together, Medicare and Medicaid provide government-subsidized health coverage to a large portion of the population, 47.2 million for Medicaid and 54.6 million for Medicaid as of 2010.[4] The launch of the Center for Medicare and Medicaid Innovation (CMMI) enabled HHS to test innovative payment techniques and service delivery models that could reduce costs and improve quality in the Medicare and Medicaid programs. With CMMI, the ACA gave HHS

a mechanism to partner with providers as it conducted these experiments.[5] One early test at CMMI, of the Pioneer Accountable Care Organization model, offers insights about how experienced medical providers supported innovative payment approaches and how the findings influenced changes to the MSSP.

ISSUE BACKGROUND

According to the Institute of Medicine about 30 percent of spending for health care goes to unnecessary services, administrative overhead, and other wasteful spending; in 2009, this amounted to $750 billion nationally.[6] Historically, doctors had limited incentives to reduce the costs of treatment because the core payment approach offered them fees for each service provided, which created incentives to focus on growing the volume of services rather than on providing quality outcomes or mitigating the total costs of care. The theory behind the ACO programs is that if given the opportunity to earn bonuses by reducing total spending and improving quality, providers will have more balanced incentives and will focus more on what is appropriate for their patients and less on billing for more and more services.

Medicare Shared Savings Program

In ACO programs, Medicare determines the population that an ACO will be accountable for and sets a spending target for that population. If at the end of the year, the ACO's population costs Medicare less than the spending target and meets specific quality standards, the ACO will receive a share of those savings. Conversely, if the ACO's population costs Medicare more than the spending target, that ACO may owe Medicare payment as a share of those losses. Most ACOs prefer to enter "shared savings only" contracts, which gives them limited risk exposure while they change their organizational culture and care processes to manage their population's health. More confident organizations may opt for the "shared savings and losses" contracts if they deem the financial opportunity large enough and the risk of losses manageable. Over time, HHS hopes that more ACOs will move to greater levels of risk, on the theory that greater accountability will drive better performance. In the first year of the MSSP, more than 100 organizations across the country participated, but fewer than 10 took on "shared savings and losses" contracts.[7]

Pioneer accountable care organizations

Parallel to the MSSP, CMMI designed the Pioneer ACO Model to test more ambitious and risky design elements, with a goal of determining which of those elements the MSSP should incorporate as permanent features in future years. Out of more than 70 applicants, the agency selected 32 Pioneer ACOs, including both hospital systems and large medical groups in urban and rural regions. Like the MSSP, the Pioneer ACO Model held providers to a financial target and quality scorecard. However, Pioneer was designed for providers already experienced in population health management and ready to take on financial risk for potential losses starting on day one. In exchange for taking on significant levels of financial risk, CMMI offered Pioneer ACOs a number of program features designed to enhance their chances of success.

CMMI staff assigned Pioneer organizations a set list of patients at the start of the year to begin focusing their care management efforts, rather than having a patient list that could change throughout the year as new patients came into Medicare and others sought care from different providers. Having this enhanced level of certainty helped Pioneer ACOs better target their investments in staff time to engage with complex patients and those with known chronic conditions.

CMMI also waived certain payment rules, like requiring a three-day stay in a hospital before Medicare would pay for a skilled nursing facility admission. This rule had long been in place to prevent waste in the system on the theory that providers might otherwise overuse skilled nursing facilities. Because ACOs were now holistically accountable for the cost and quality of care, CMMI hypothesized that the organizations would use the waiver responsibly, safely decreasing Medicare costs by avoiding unnecessary in-patient hospital stays for patients who were stable enough to go straight to a nursing facility instead. Testing these features required a certain level of trust that ACOs would not game or abuse the new legal flexibilities. But HHS also detailed expectations of the processes that organizations needed to set up in order to ensure that the waiver applied only to appropriate cases and that no harm came to patients. Plus, HHS would monitor their efforts.

EVIDENCE AVAILABILITY

HHS used multiple types of evidence to assess the Pioneer ACO Model. First, CMMI fielded a team of researchers who conducted a formal evaluation to answer two key questions: (1) Did the Pioneer ACO Model result in lower Medicare spending than would have otherwise occurred without harming the quality of care? and (2) Were there certain types of ACOs that were more likely than others to be successful?

Second, the Office of the Actuary within the Medicare agency played a critical role in reviewing the formal evaluation findings and conducting additional analyses to assess whether the program met criteria to qualify for expansion into permanent programs, as laid out in the ACA. In contrast to the formal evaluation, which looked retrospectively at what happened in the Pioneer ACO Model, the Office of the Actuary had responsibility for prospectively predicting the impact of program features. This required consideration of the likelihood of different behavioral responses by health care providers to specific circumstances.

Third, CMMI collected a great deal of qualitative and quantitative information on how the program performed operationally. It sponsored a learning system that brought ACO participants together to share their experiences and to exchange ideas on solving common problems, such as how to interpret data files or how to explain their transformative care work to patients. CMMI collaborated with Pioneer ACOs to create a curriculum of topics. One module, for example, brought together the ACOs that implemented the three-day-stay waiver to discuss the best way to partner with skilled nursing facilities, streamline the process of readying patients to go home, and develop useful measures for success. Through

these interactions and by creating new data tools, contract templates, legal instruments, and processes for collaboration, CMMI generated a wealth of operational lessons for the agency to consider in generalizing from the Pioneer ACO Model.

EVIDENCE USE

The independent evaluation demonstrated that Pioneer organizations saved Medicare a total of $384 million in 2011 and 2012.[8,9] A significant part of these savings came from Medicare beneficiaries using the hospital less and shifting care to doctors' offices. At the same time, the evaluation found that Pioneer organizations achieved a higher quality of care and sustained that performance throughout the evaluation period, confirming that savings did not come at the cost of reducing quality. The Office of the Actuary reviewed the evaluation findings and modeled additional analyses by using assumptions of the number of likely qualified organizations in the country, whether those organizations would begin as high-cost or low-cost providers, how strongly Pioneer program features would lure providers away from other types of contracts, and other key behavioral parameters.

Based on these analyses, the staff in the Office of the Actuary predicted that savings would accrue to the Medicare Trust Fund if Medicare's permanent ACO program, the MSSP, included specific Pioneer design elements, such as providing a patient list to the organizations at the beginning of the year and giving them the option of realizing a higher share of savings if they agree to accept increased financial risk. The Office of the Actuary presented its findings in April 2015, certifying the expectation of cost savings.[10] Based on the certification by the Office of the Actuary's staff, HHS decided to include these Pioneer ACO Model design elements into a new component of the MSSP through regulatory action.[11]

Based on CMMI's operational experience, HHS policy officials determined that the three-day-stay waiver did not result in adverse patient outcomes or questionable business practices by providers and was a cost-effective tool for case management in rehabilitation settings. Thus, it incorporated the three-day-stay waiver into the MSSP for organizations taking financial risk. HHS finalized these new MSSP features in June 2015, approximately four and a half years after the launch of the Pioneer ACO Model.

As important, HHS staff recognized that not all of the features tested through the Pioneer ACO Model were ready for large-scale adoption, but they could still be translated into program elements to test in a new ACO experiment. For example, CMMI learned that some organizations wanted to change how they receive Medicare payments: rather than a stream of payment for individual services with an additional payment of shared savings at the end of the year, some ACOs wanted their payments throughout the year to be lumped together into larger monthly payments, called "capitation," and calculated on a per-patient basis. Receiving more predictable and larger amounts at a steady pace would allow them to better plan their investments responsibly. ACOs also found that many (often the majority) of the patients assigned to them were not members of the population they were accountable for, which greatly

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diluted the value of the care interventions and presented missed opportunities to help patients in need. Therefore, they asked for the ability to approach patients CMMI may not otherwise have assigned to them to "join" their ACO.

CMMI applied these and other lessons into the design of an even more advanced program, the Next Generation Model, which began testing in 2016. Many organizations that had participated in the Pioneer ACO Model transitioned into the Next Generation Model, a testament to the value they found in working collaboratively with HHS to rapidly cycle through experimentation and learning.

LESSONS

- ***Evidence use requires weighing many inputs***. In the case of determining how to proceed with the Pioneer model, the most important lesson was how to synthesize and give appropriate weights to all the inputs. The program team received feedback directly from the ACOs, the learning system modules, shared savings results, evaluation results, and even from members of Congress who received constituent questions. Nothing takes the place of a rigorous evaluation, but in government programs, multiple stakeholders and informational inputs need to be factored into policy decisions.
- ***Clear goals help inform the evaluation questions and resulting policy decisions***. While the Pioneer ACO Model did demonstrate savings to the Medicare Trust Fund, when designing subsequent projects, a key question involved the importance of early savings compared with longer-term care delivery transformation and provider culture change. If HHS gave a significant portion of the savings realized back to the ACOs, could this encourage more investment in care transformation and more longer-term eventual savings? When executing a program, there will likely be tremendous pressure to show results—and quickly. Setting expectations and defining metrics for success at the outset can help mitigate some of these external pressures. ■

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