



# **BUILDING ACCOUNTABLE CARE ORGANIZATIONS**

**Harold D. Miller**

**Executive Director**

**Center for Healthcare Quality and Payment Reform**



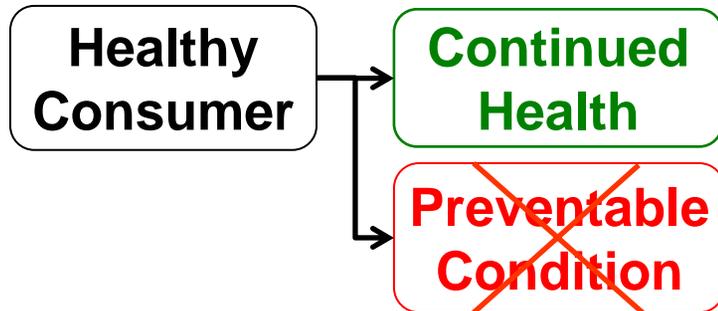
# Goal of Accountable Care Orgs: Reducing Costs Without Rationing

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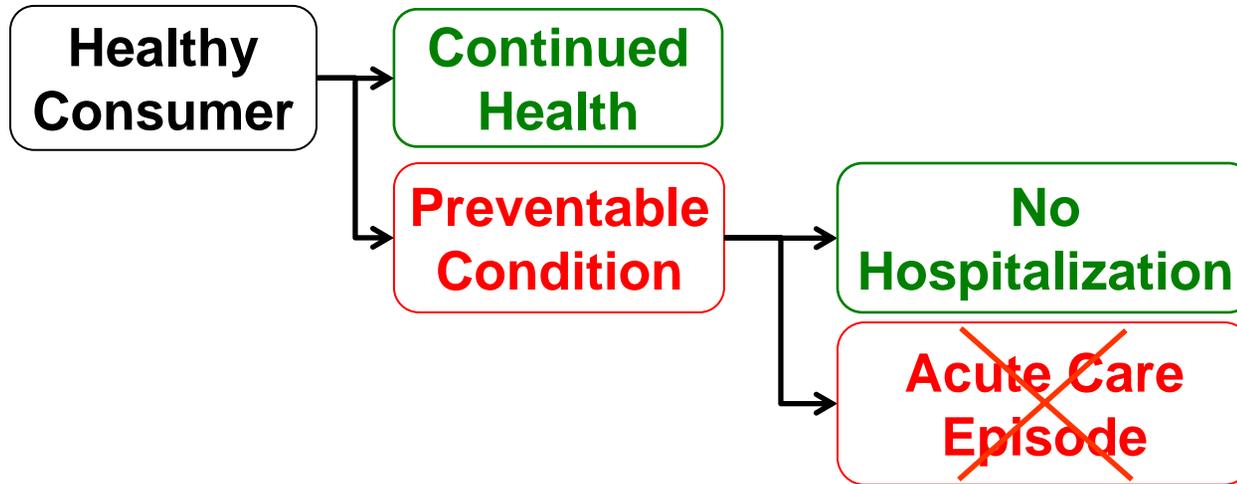
# Reducing Costs Without Rationing: Prevention

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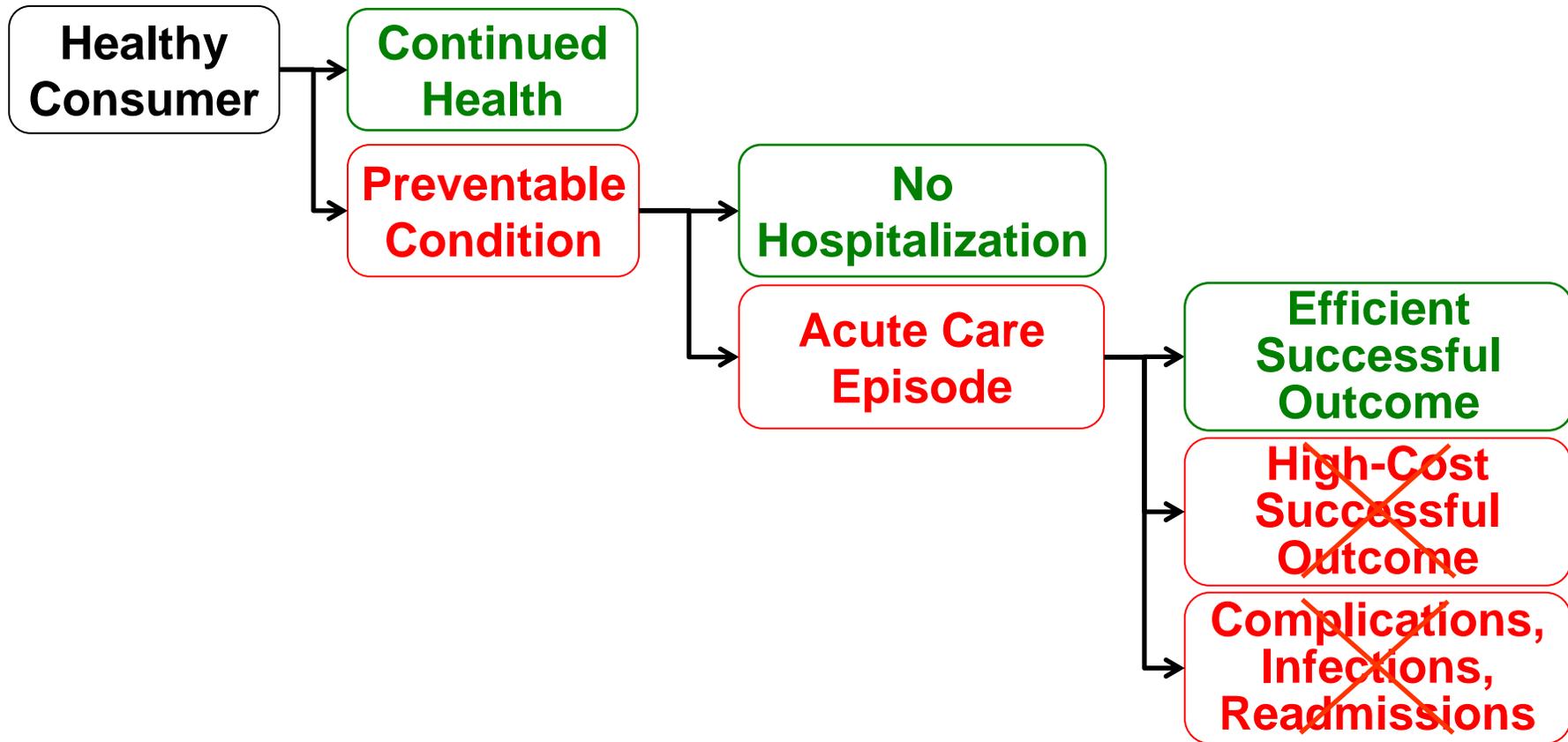


# Reducing Costs Without Rationing: Avoiding Hospitalizations

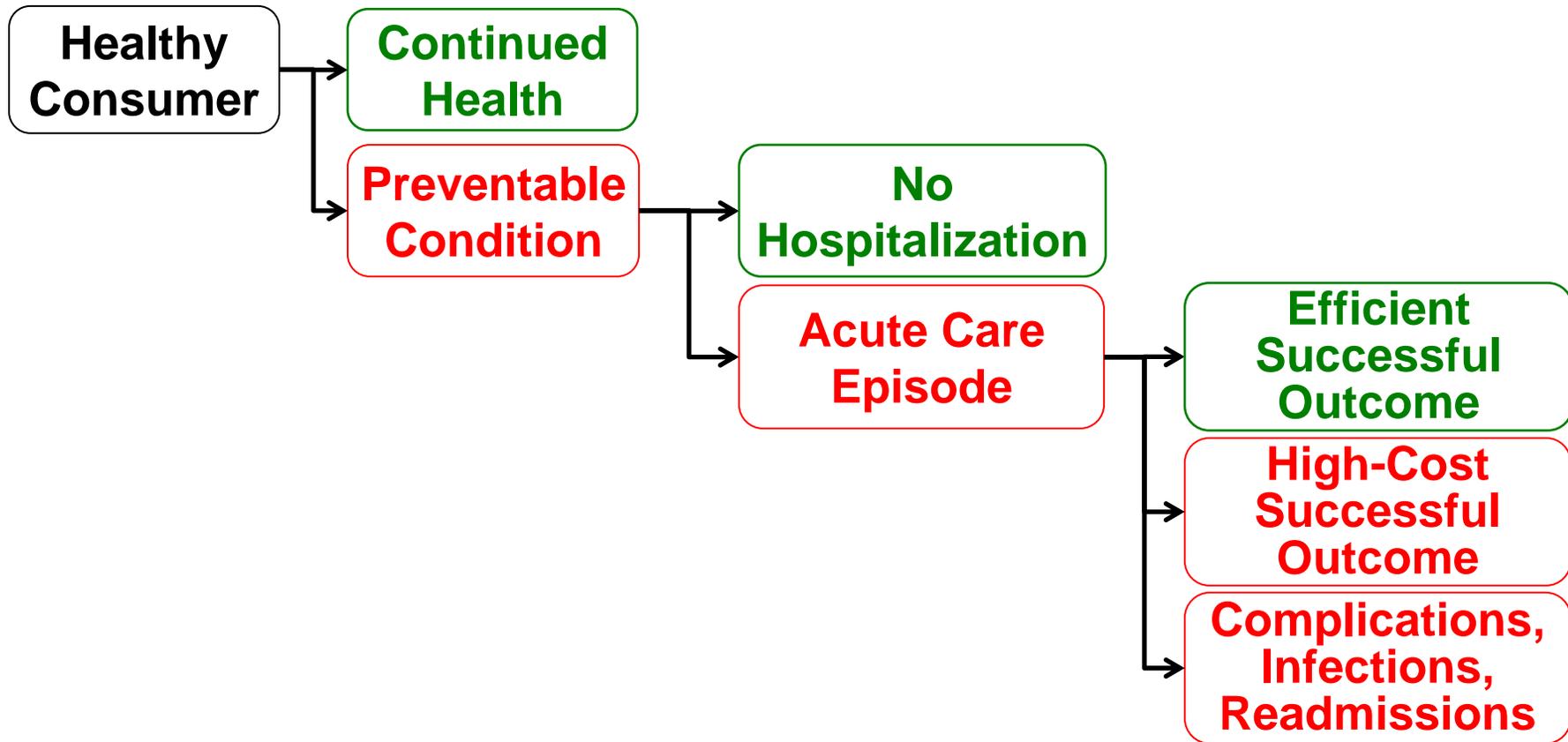




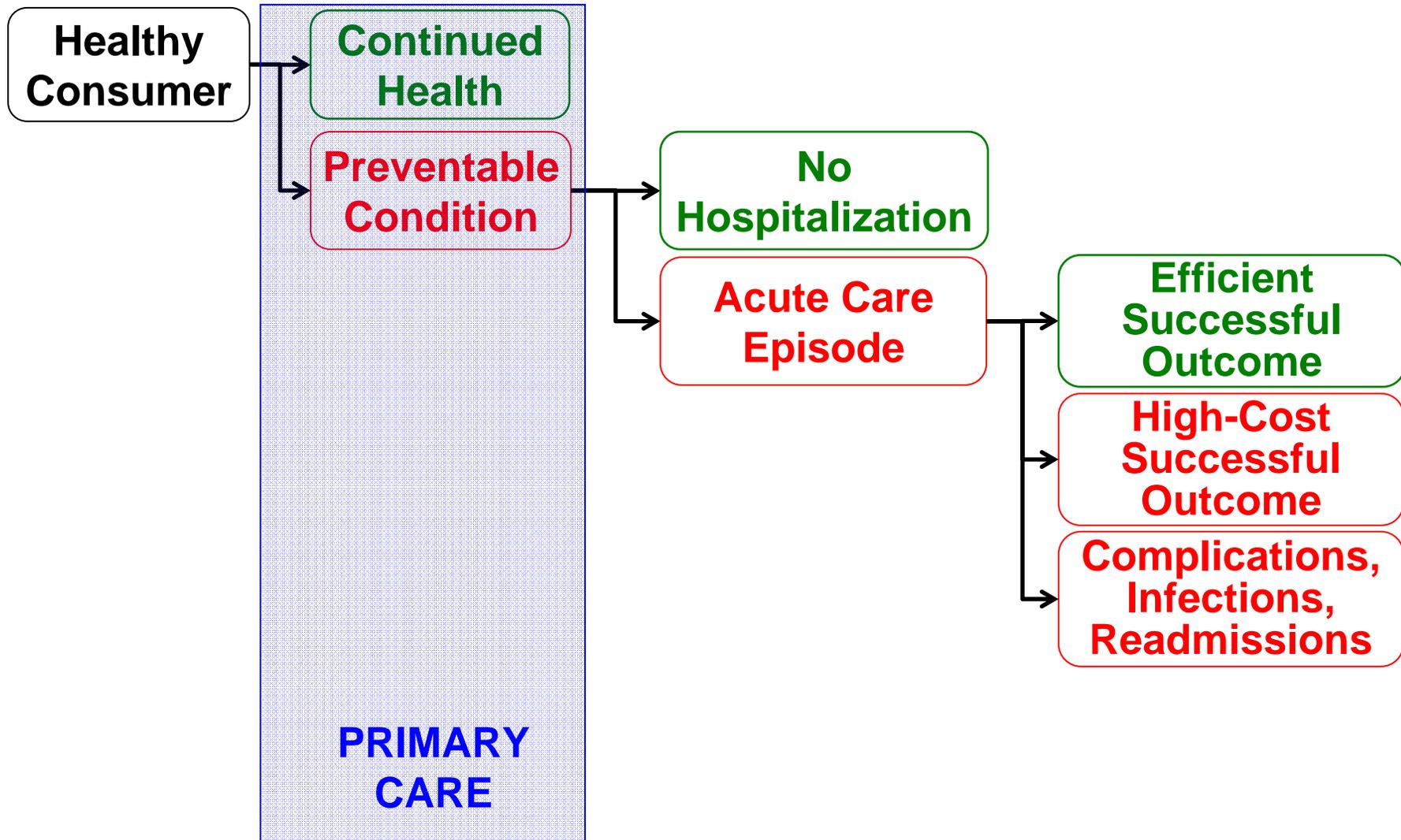
# Reducing Costs Without Rationing: Efficient, Successful Treatment



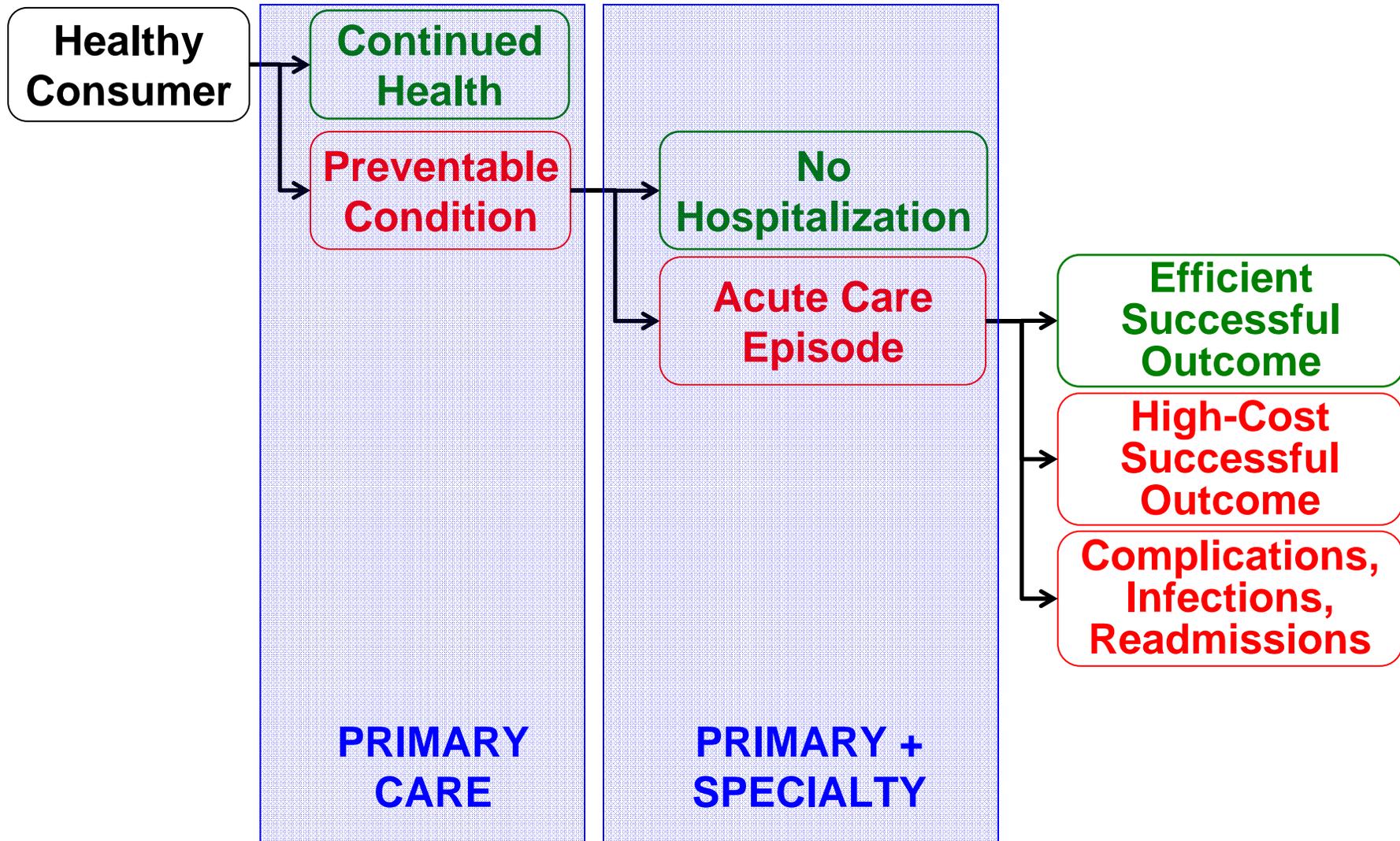
# Who Needs to Be Accountable For Achieving Better Outcomes?



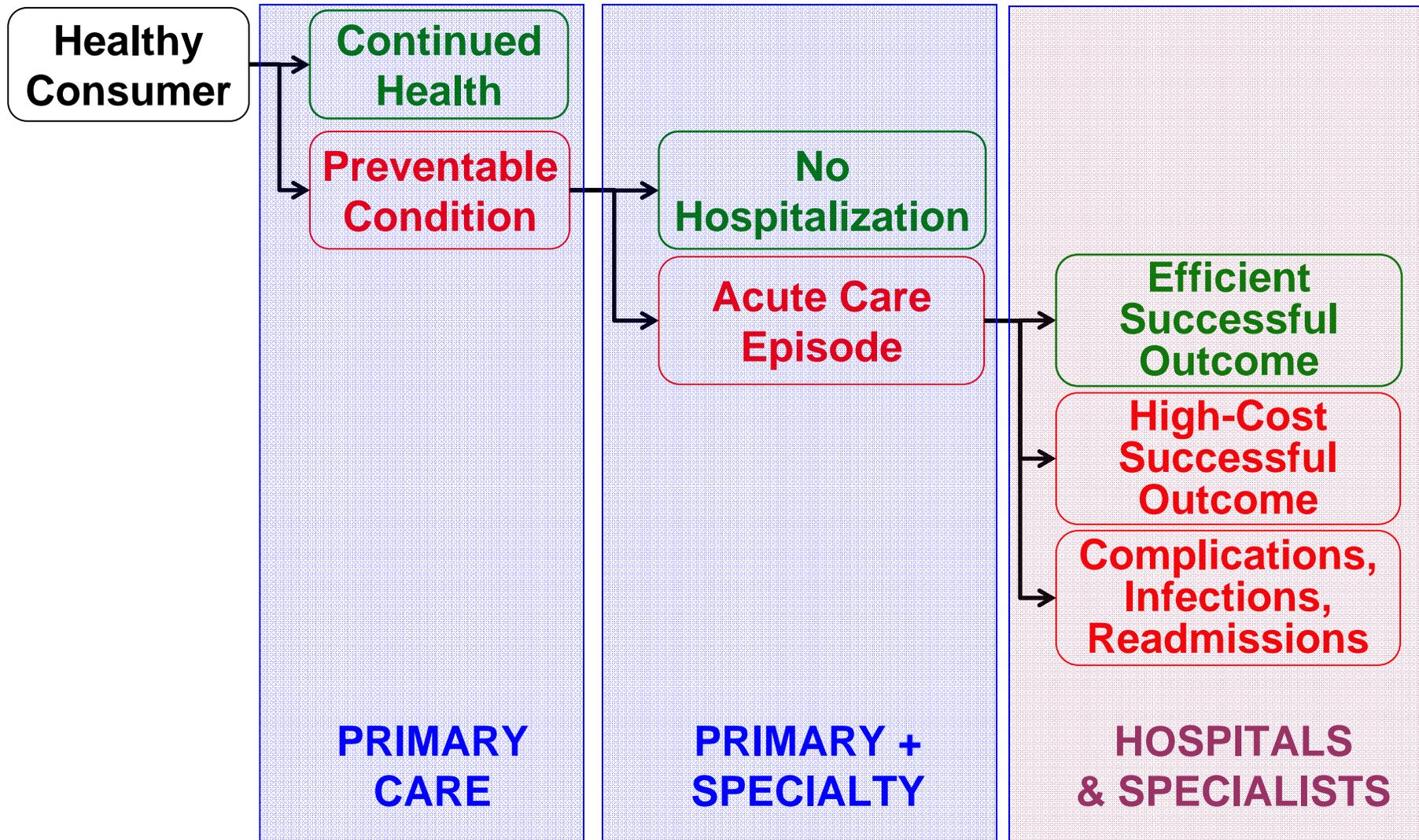
# Keeping People Well? Primary Care



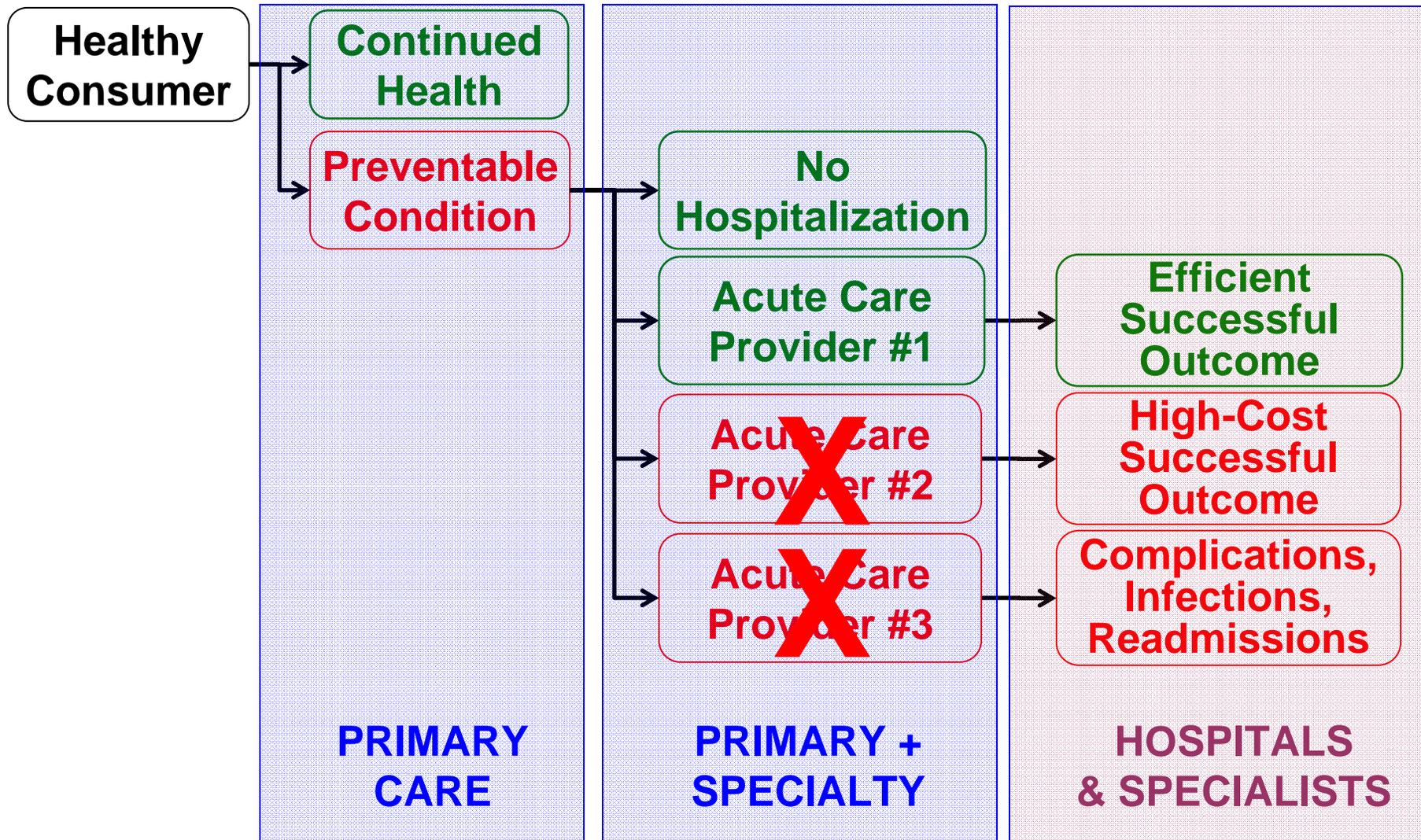
# Avoiding Hospitalizations? Primary + Specialty Care



# Better Acute Care? Hospitals and Specialists, But...

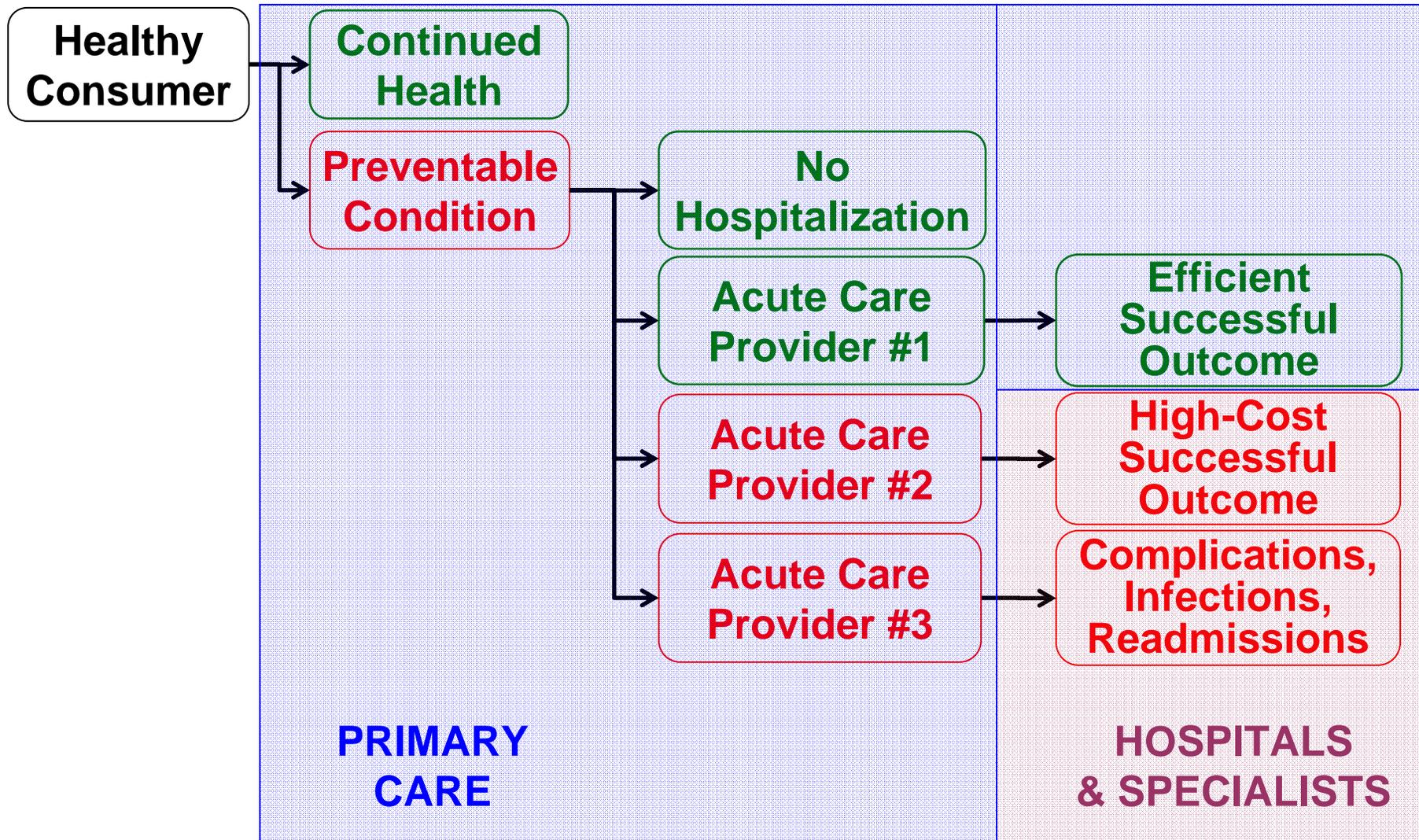


# ...MDs Choose Which Hospital (or Non-Hospital Setting) to Use

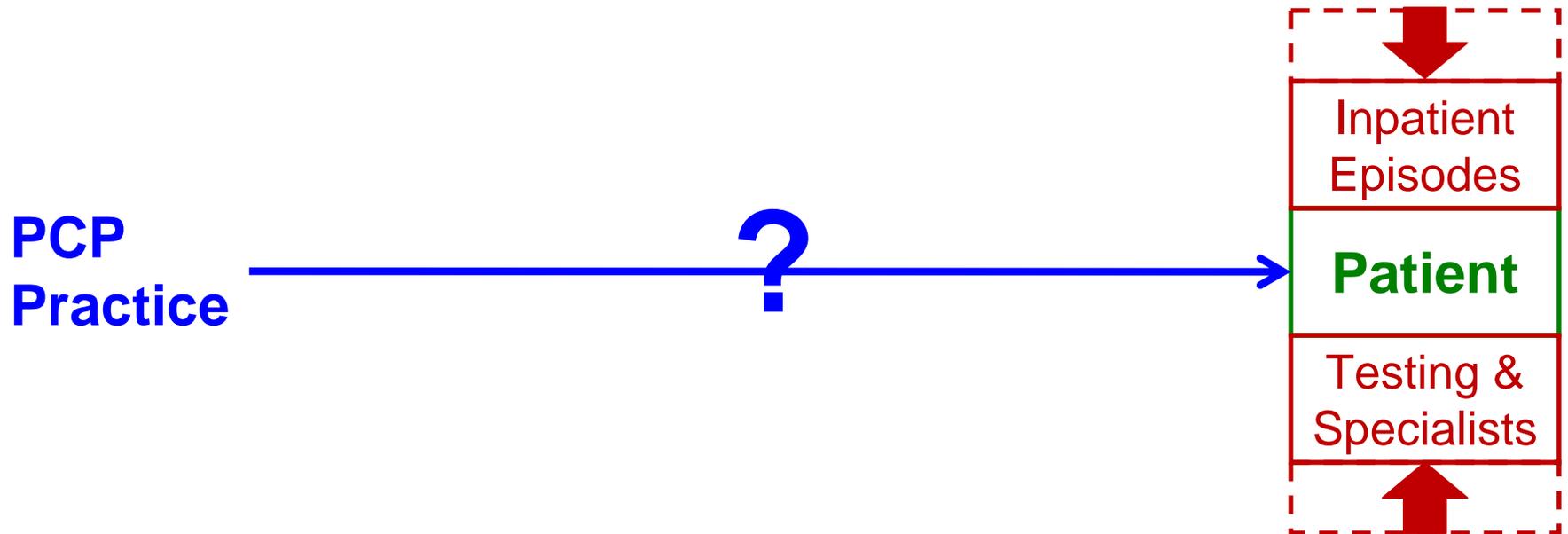




# So the Core of Accountable Care Organizations is Primary Care



# Resources/Capabilities Needed for PCPs to Manage Utilization



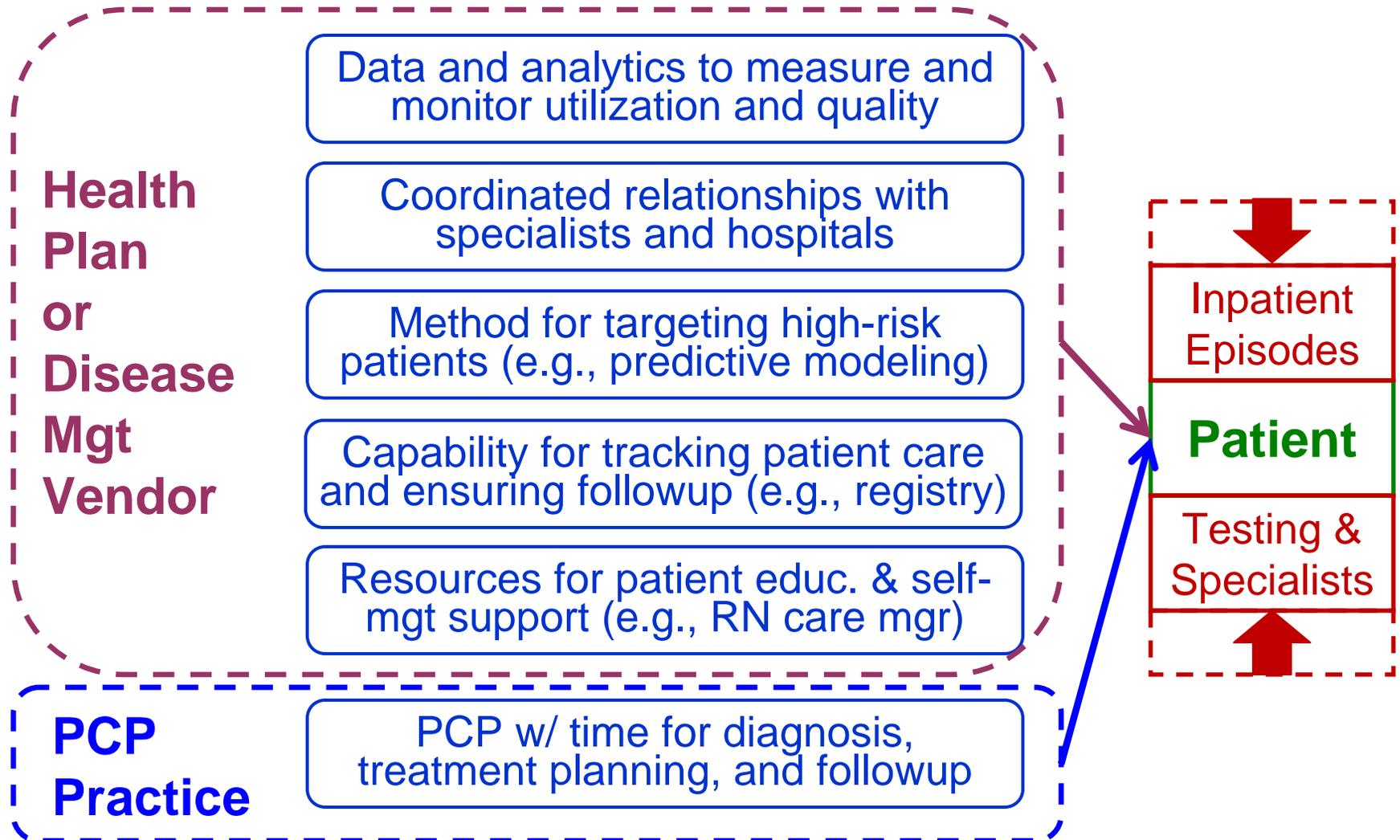
# Resources/Capabilities Needed for PCPs to Manage Utilization

## PCP Practice

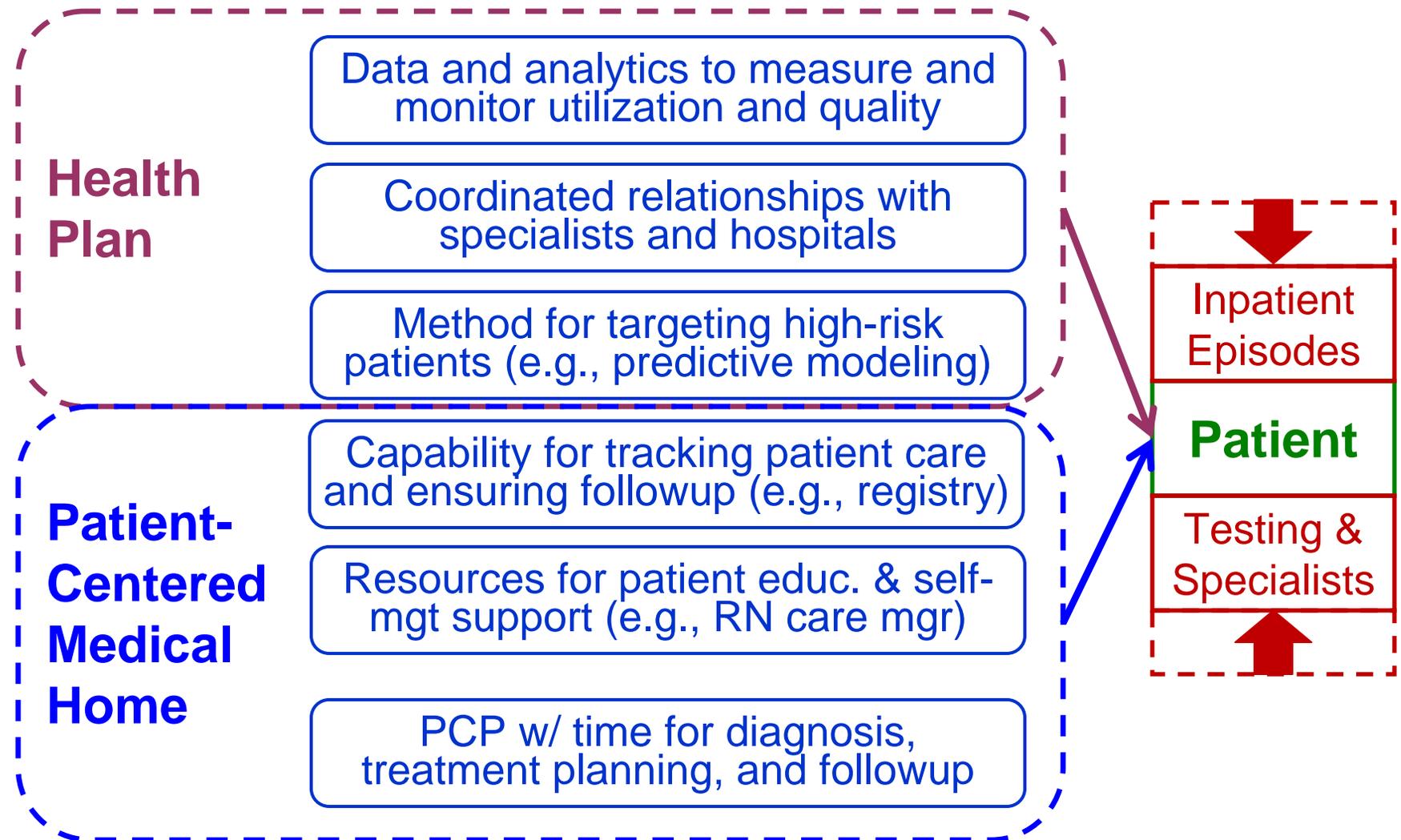
- Data and analytics to measure and monitor utilization and quality
- Coordinated relationships with specialists and hospitals
- Method for targeting high-risk patients (e.g., predictive modeling)
- Capability for tracking patient care and ensuring followup (e.g., registry)
- Resources for patient educ. & self-mgt support (e.g., RN care mgr)
- PCP w/ time for diagnosis, treatment planning, and followup



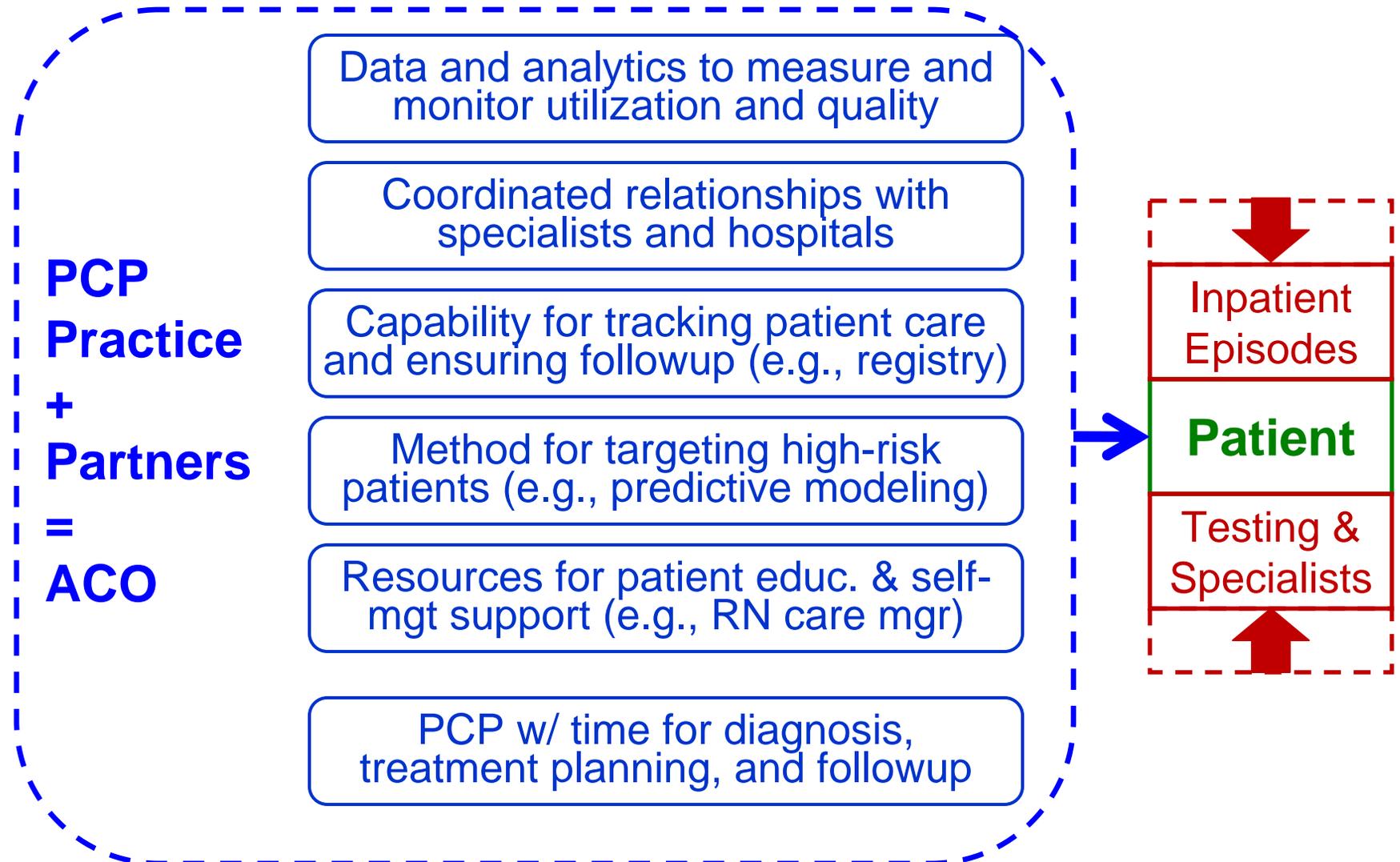
# Resources Exist Today, But Function Independently of PCPs



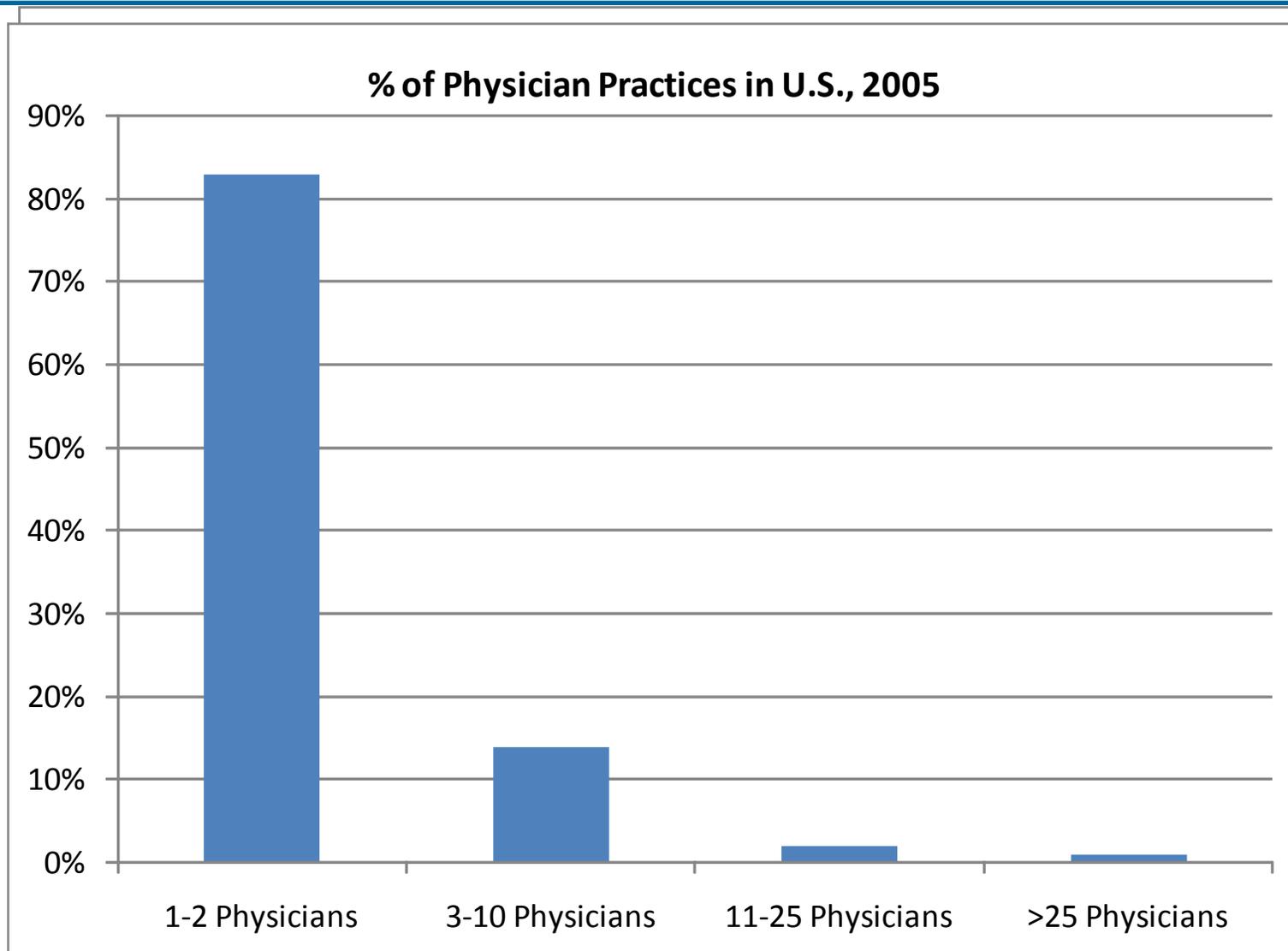
# Medical Home Initiatives Expand PCP Capacity, But Not Enough



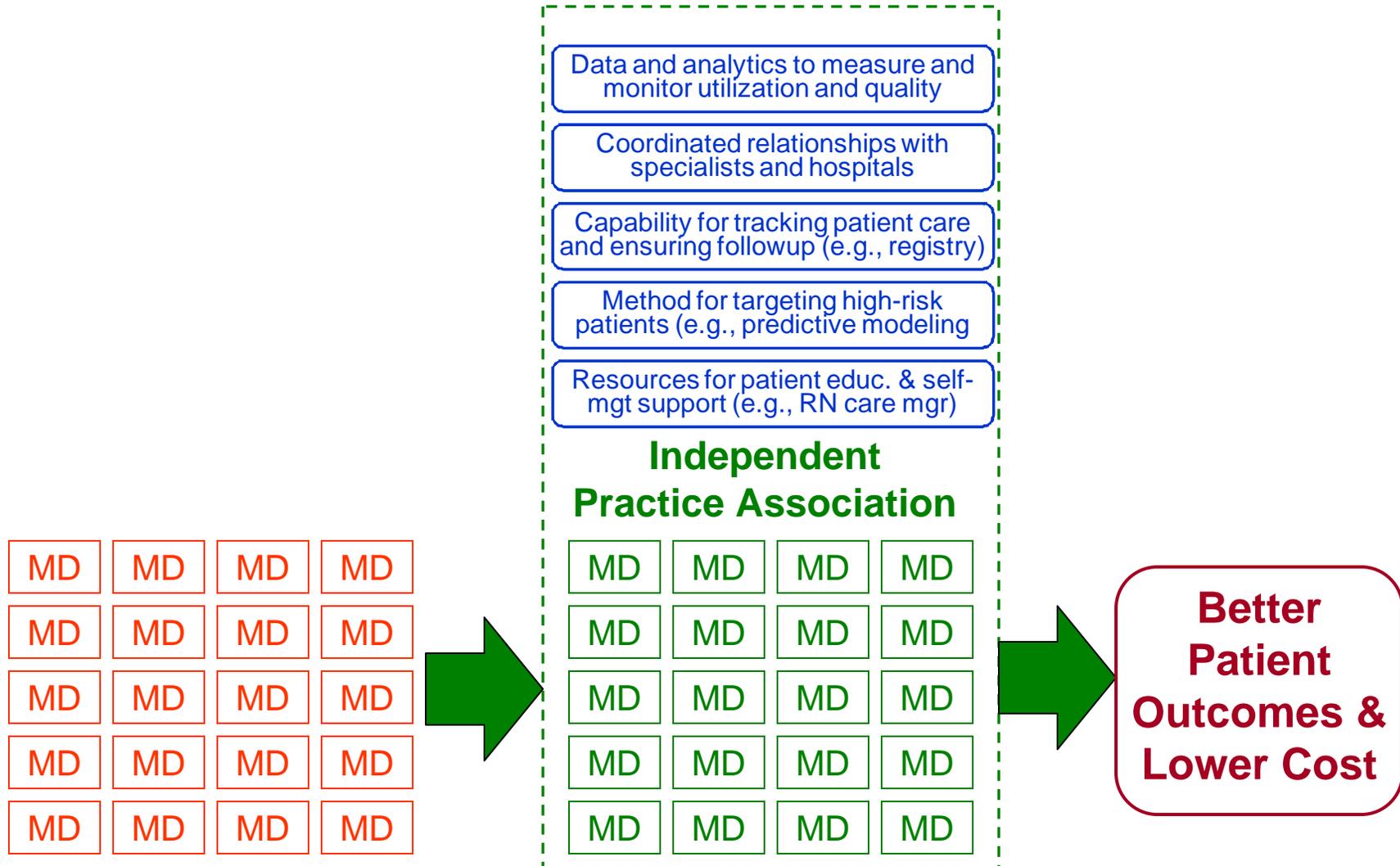
# Goal: Give PCPs the Capacity to Deliver “Accountable Care”



# Problem #1: Most Physicians Are In Very Small Practices

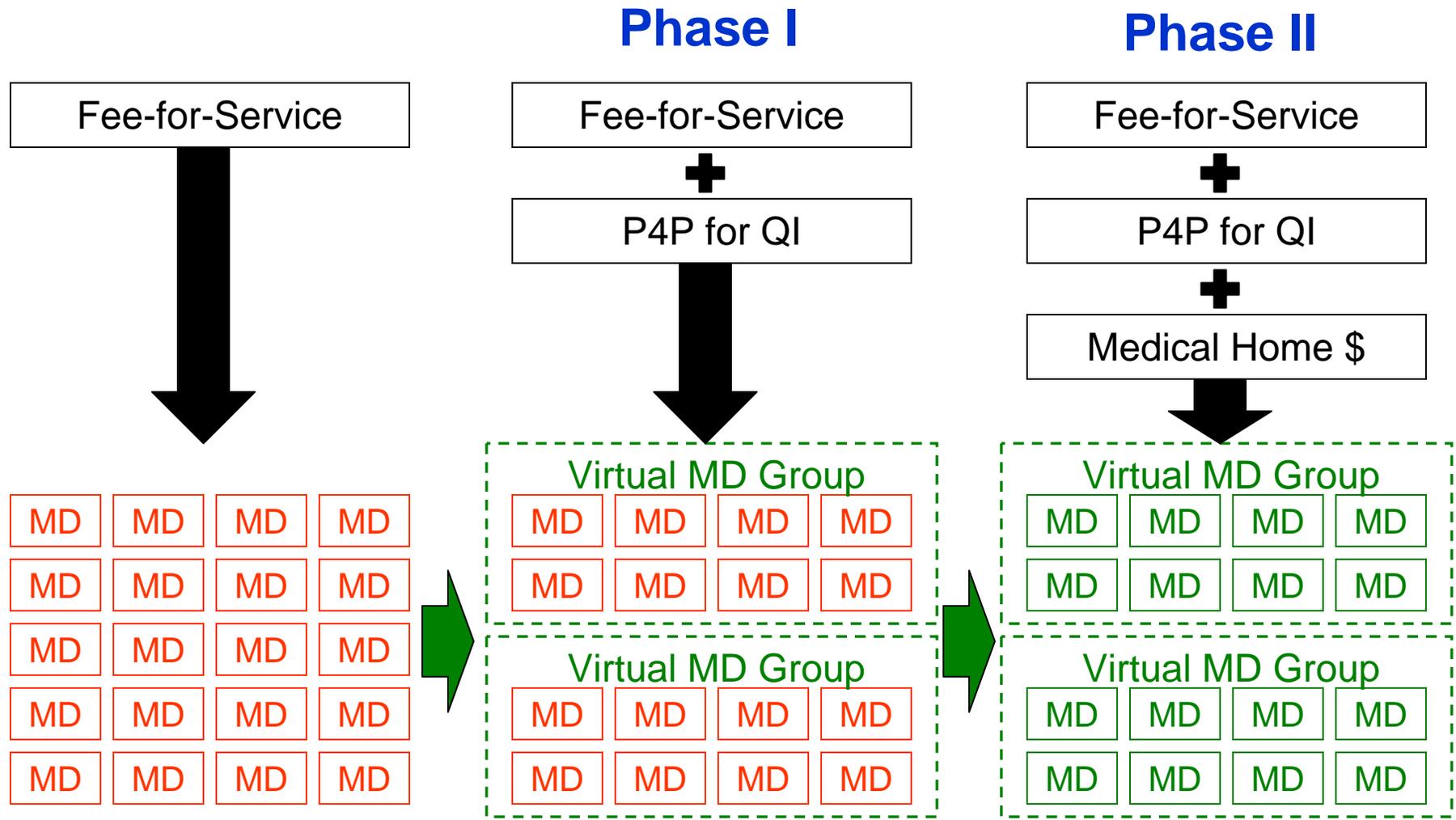


# Solution 1a: Use IPAs or Virtual Physician Orgs for Critical Mass

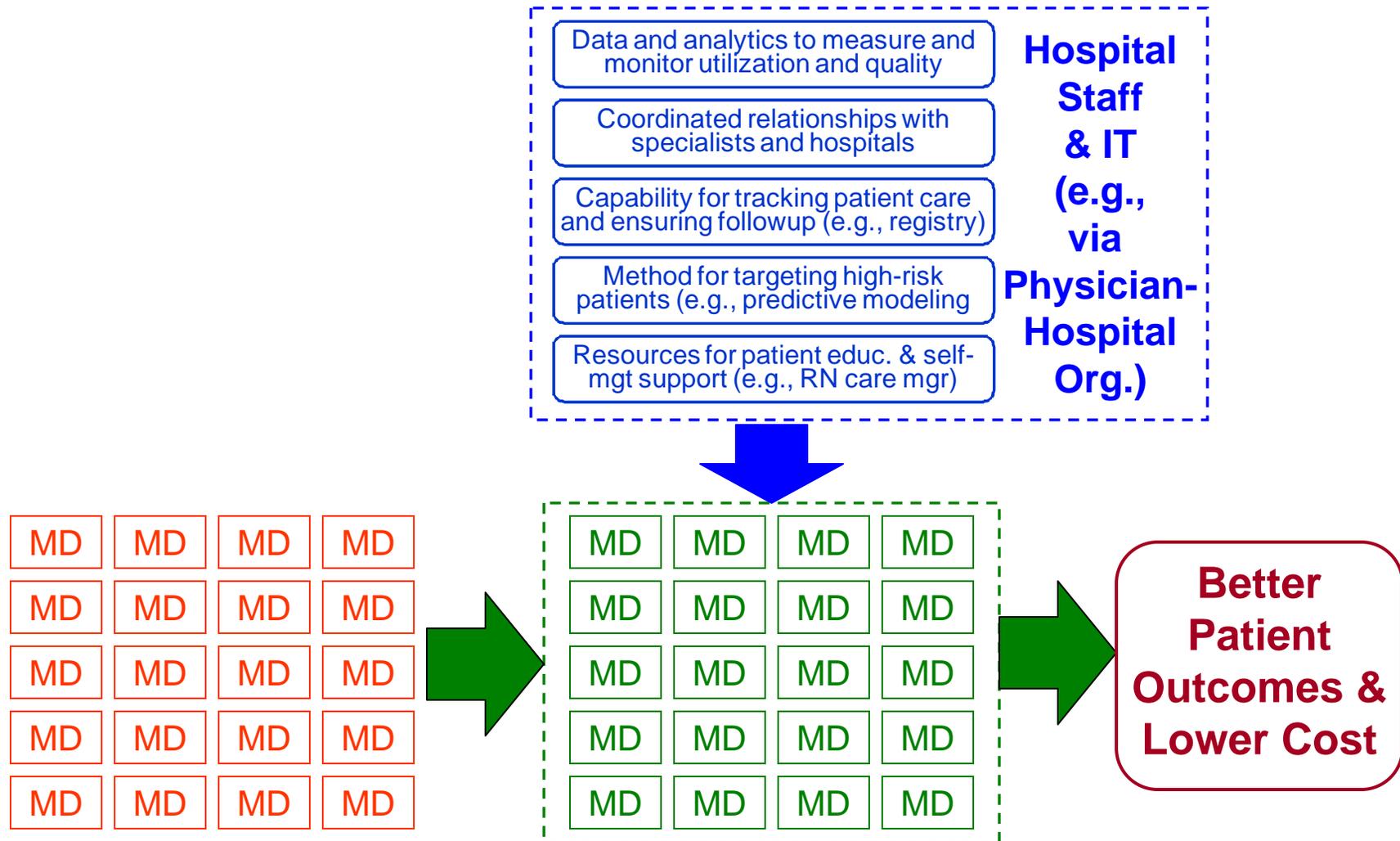




# Michigan BC/BS Physician Group Incentive Program

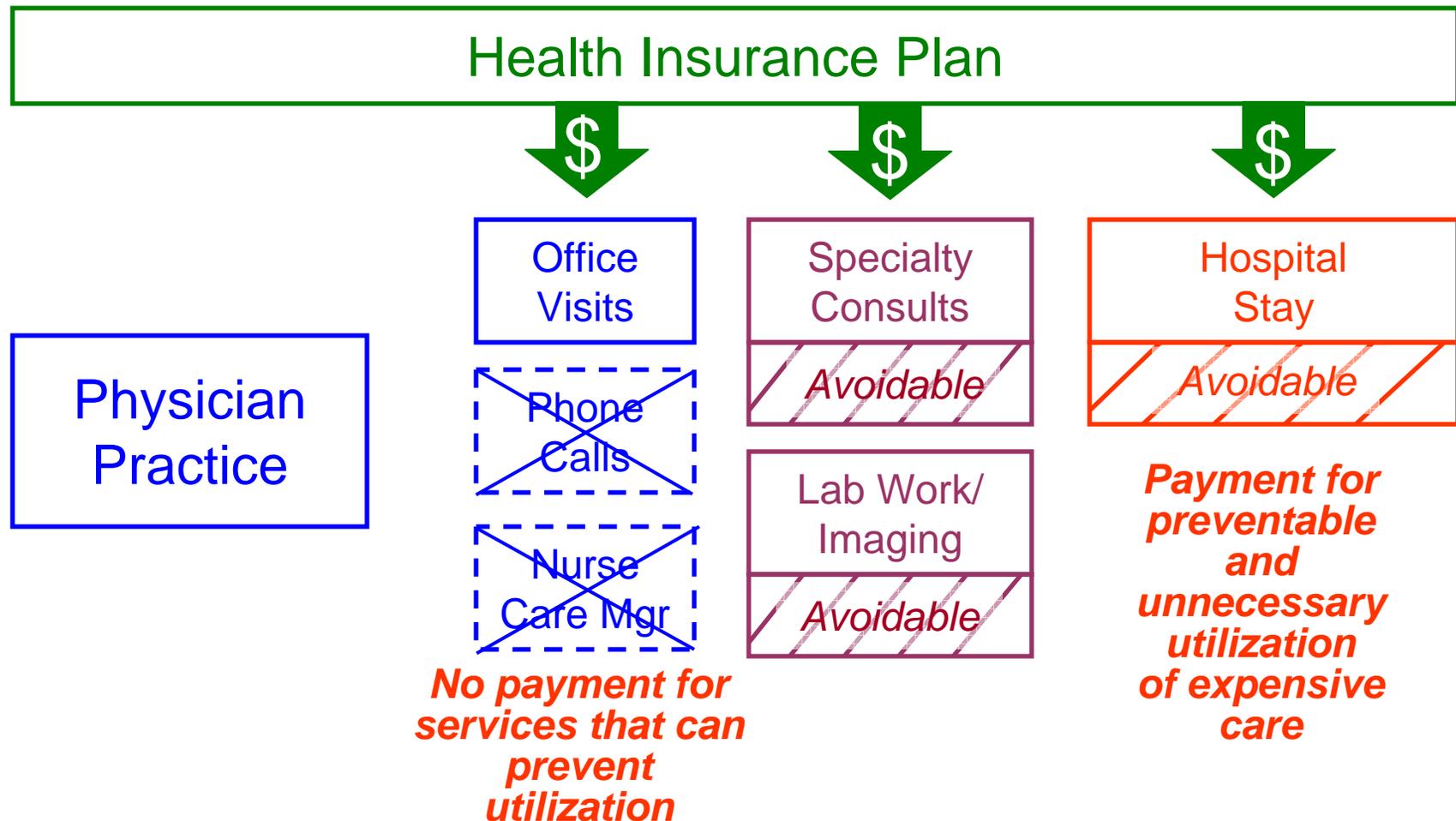


# Solution 1b: Provide Support From Hospitals to Physicians



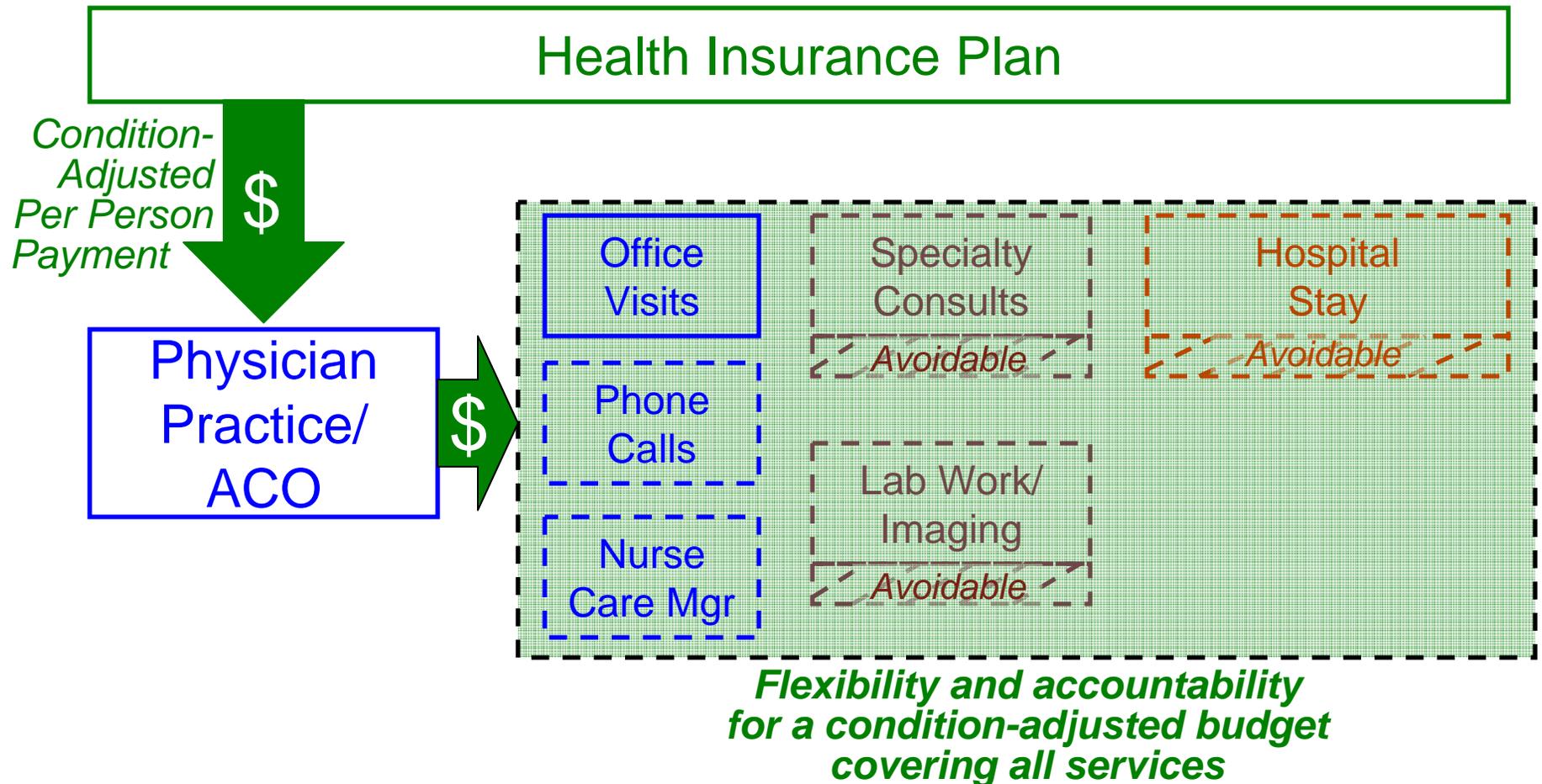
# Problem #2: FFS Neither Enables Nor Incentivizes PCPs to be ACOs

## CURRENT PAYMENT SYSTEMS



# But It's a Big Jump to a Full Global Payment System

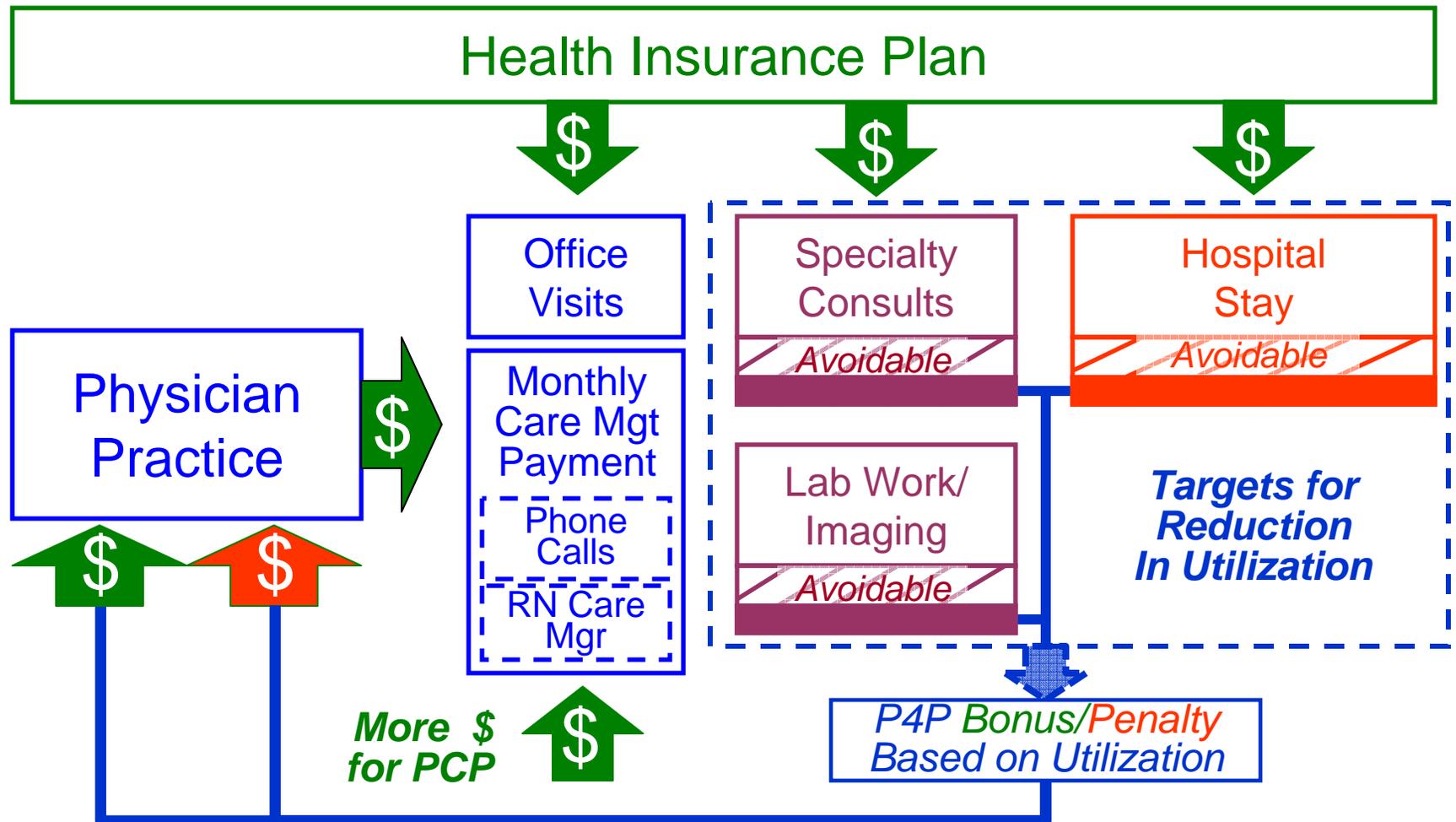
## FULL COMP. CARE/GLOBAL PAYMENT





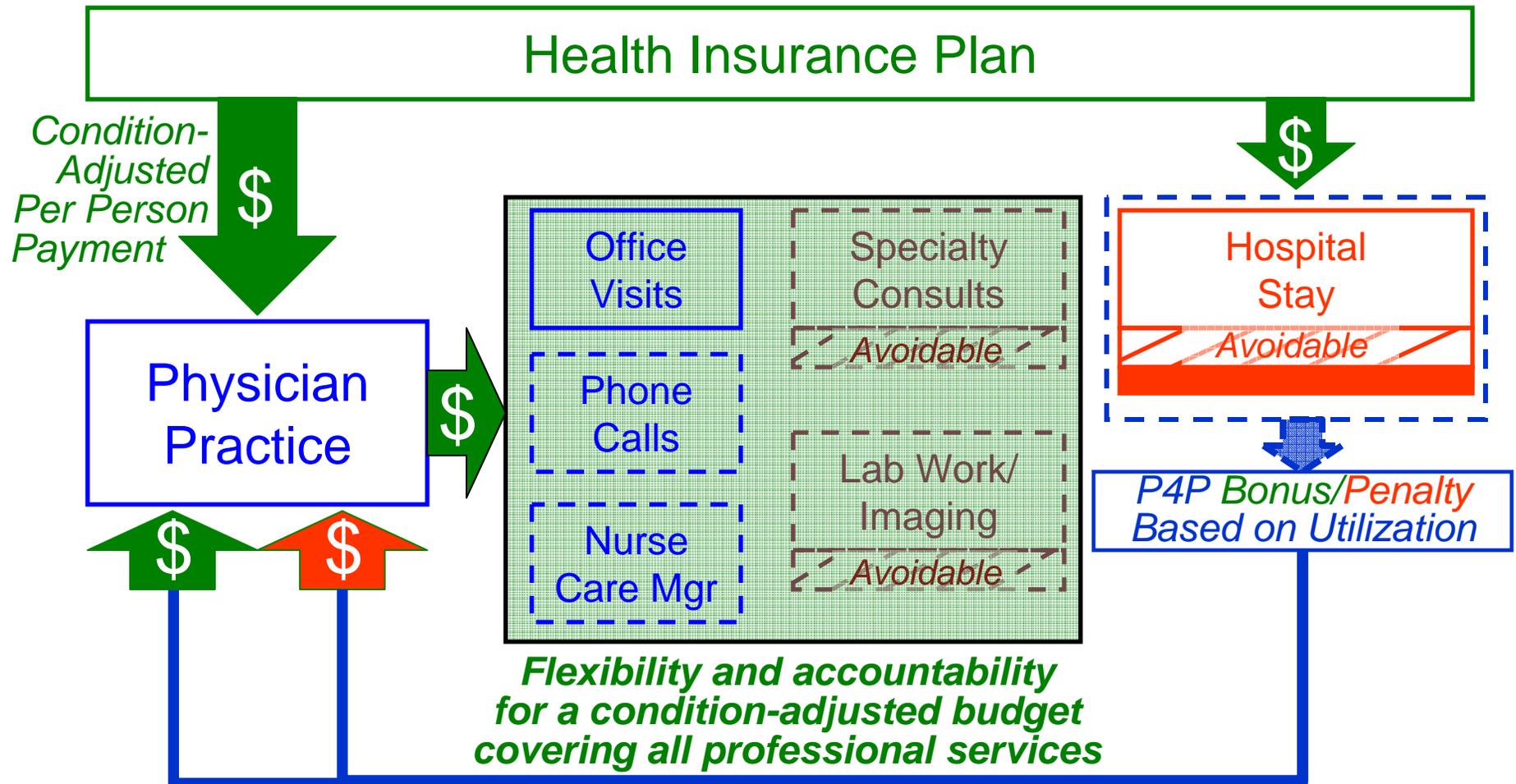
# Solution: Simulate the Flexibility & Incentives of Global Payment

## CARE MGT PAYMENT + UTILIZATION P4P



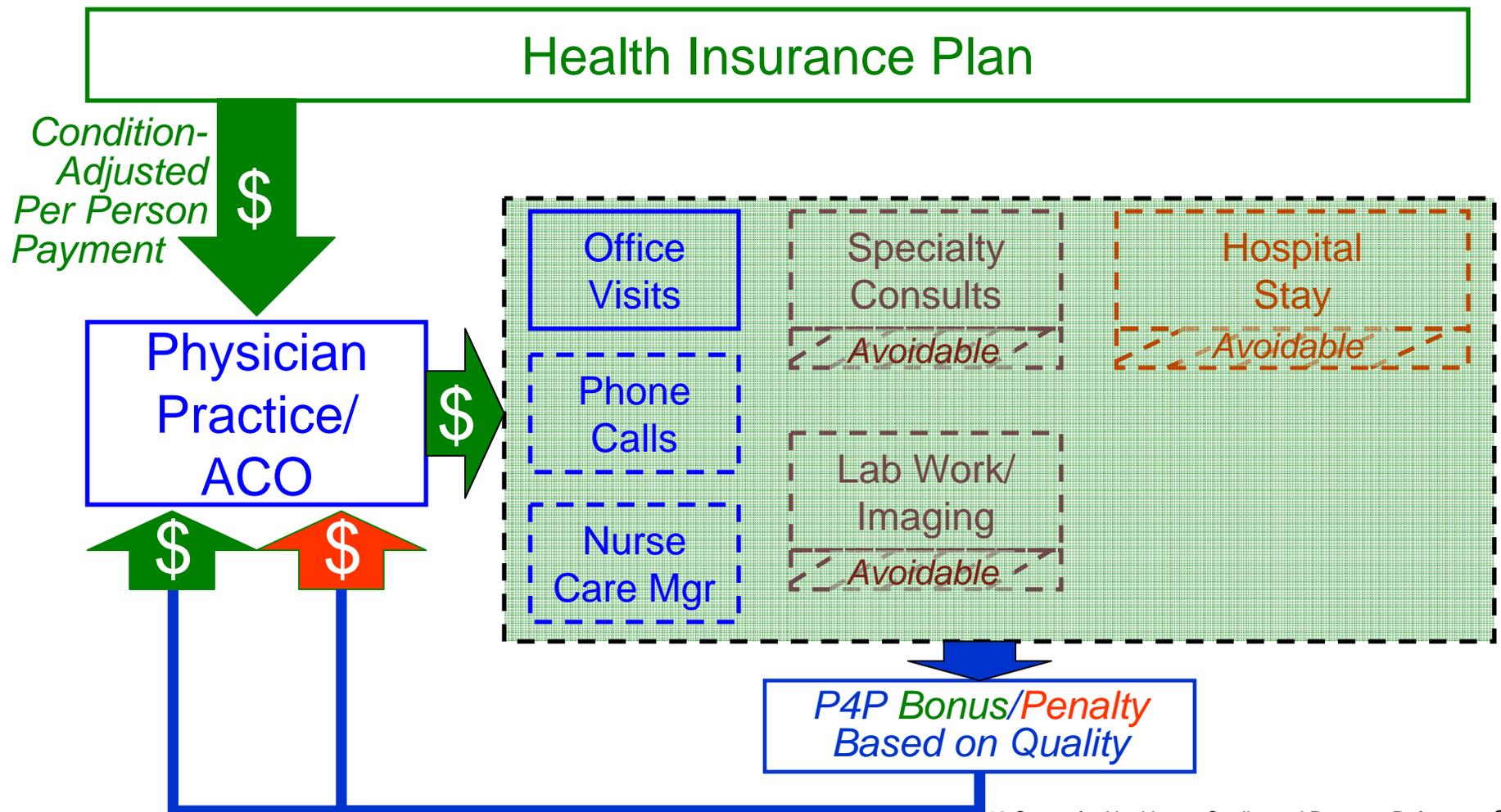
# For Those Practices That Are Ready: Partial Global Payment

## PARTIAL GLOBAL PMT (Professional Svcs)



# Ultimately: Global Payment With Quality Incentives

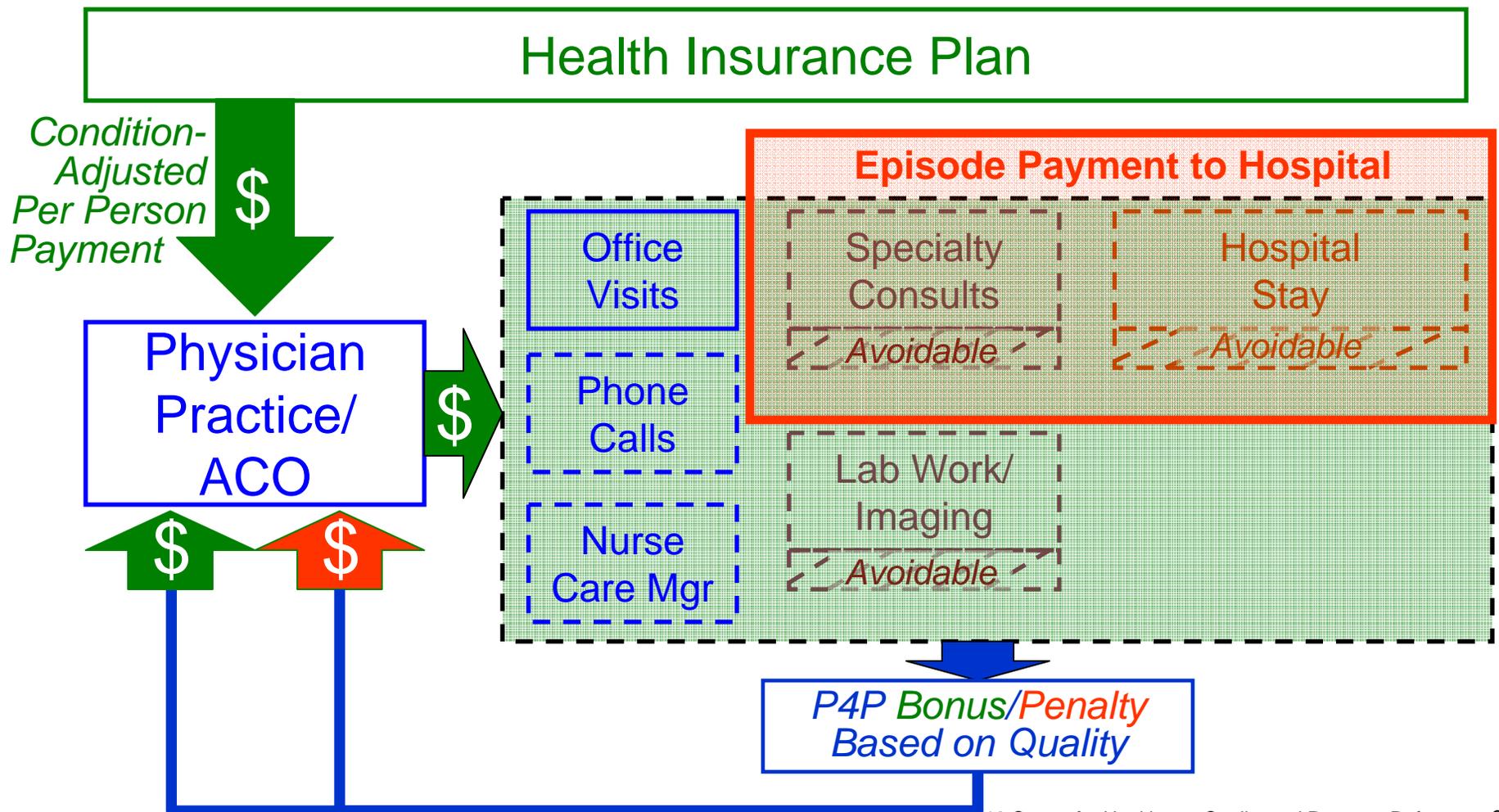
## FULL COMP. CARE/GLOBAL PMT + QUALITY P4P



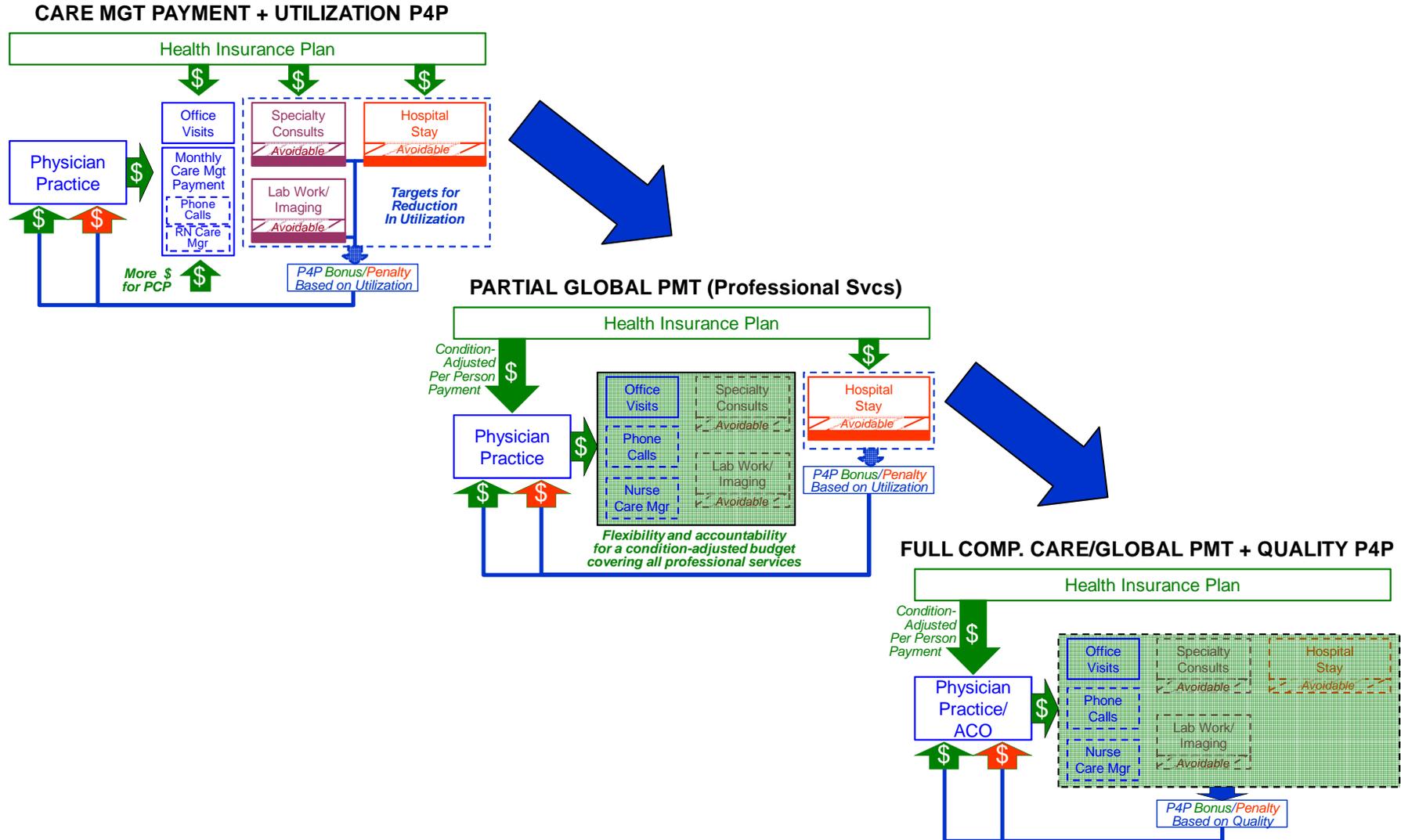


# Episode Payments for Acute Care Help the ACO Manage Costs

## FULL COMP. CARE/GLOBAL PMT + QUALITY P4P



# Transitioning to Accountable Care Payment





# Don't Let the Perfect Be the Enemy of the Good

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## EXAMPLES OF COST REDUCTION OPPORTUNITIES

Better Management of Complex and Low-Income Patients

Greater Efficiency & Improved Outcomes for Inpatient Care

Improved Outcomes and Efficiency for Major Specialties

Reduction in Preventable ER Visits & Admissions

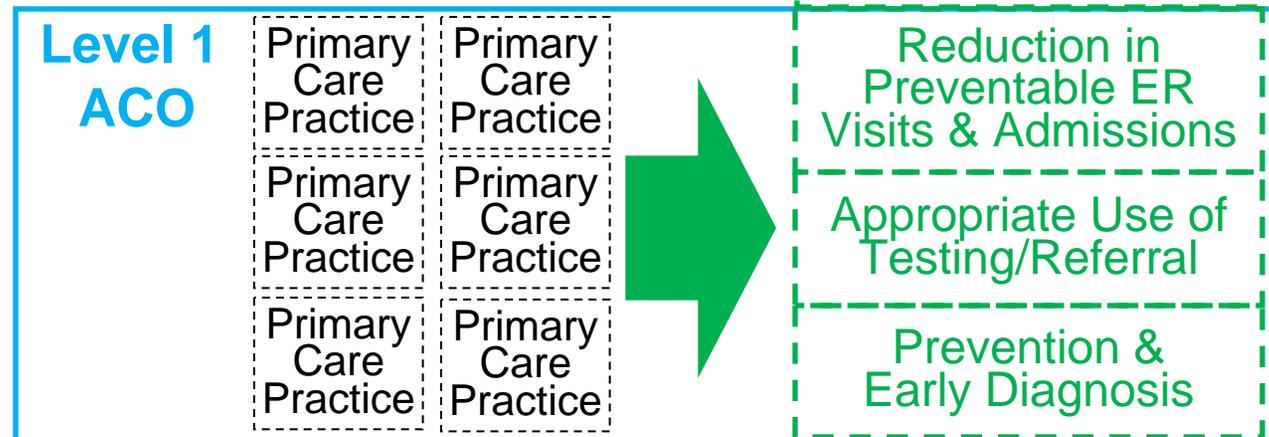
Appropriate Use of Testing/Referral

Prevention & Early Diagnosis

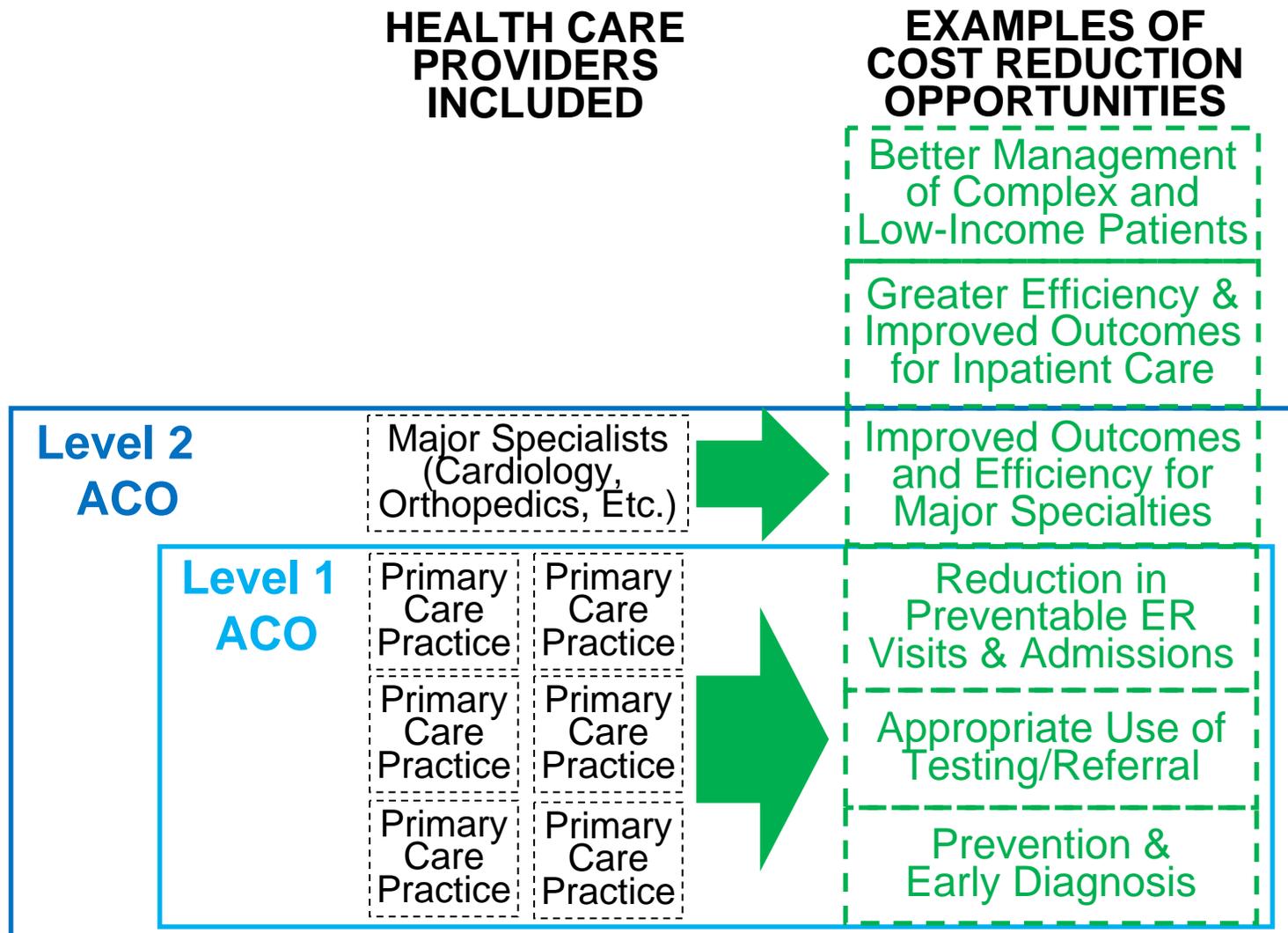
# “Level 1” ACO: PCPs Only

## HEALTH CARE PROVIDERS INCLUDED

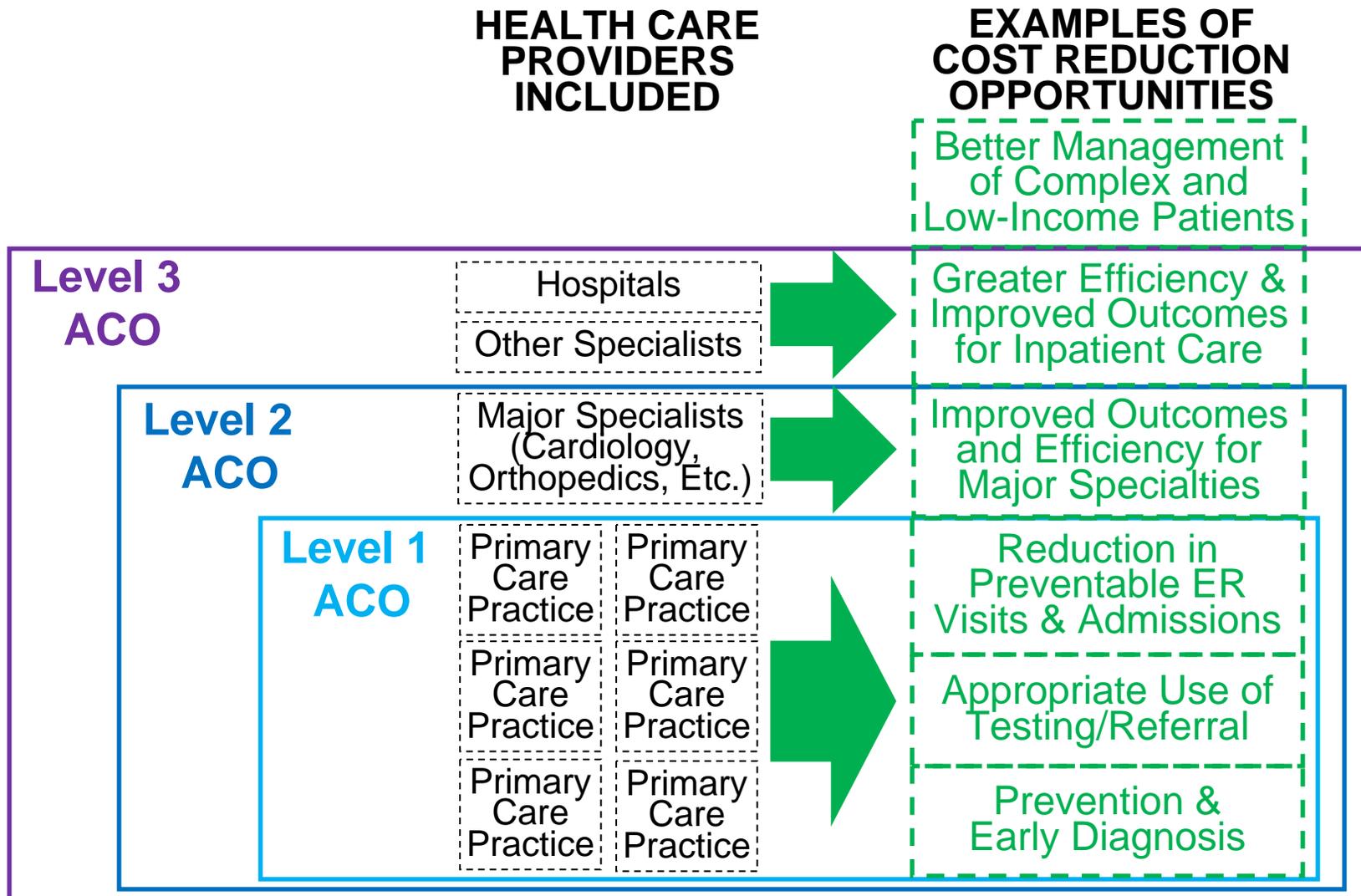
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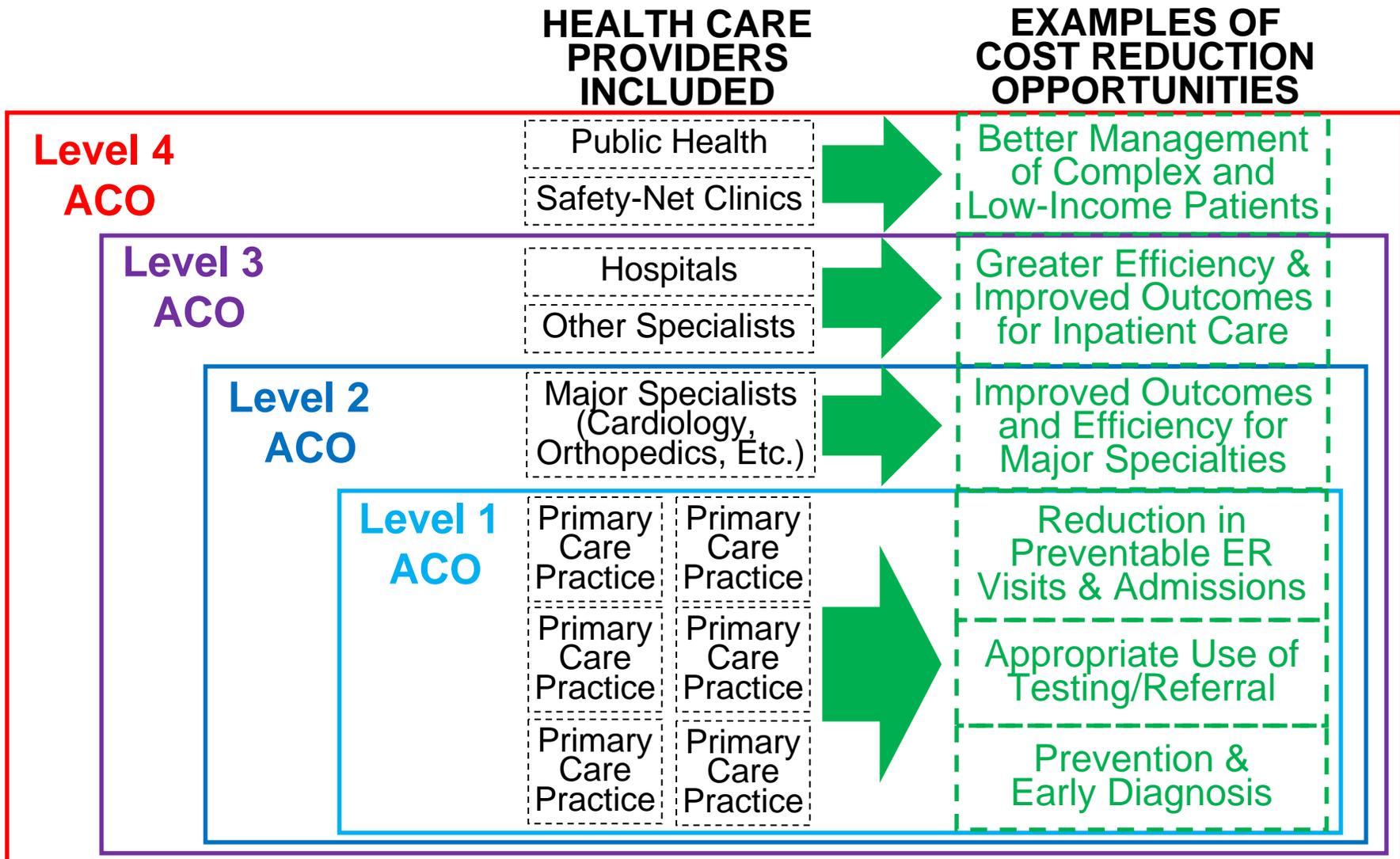
# “Level 2” ACO: PCPs + Key Specialists



# “Level 3” ACO: PCPs + Specialists + Hospital(s)

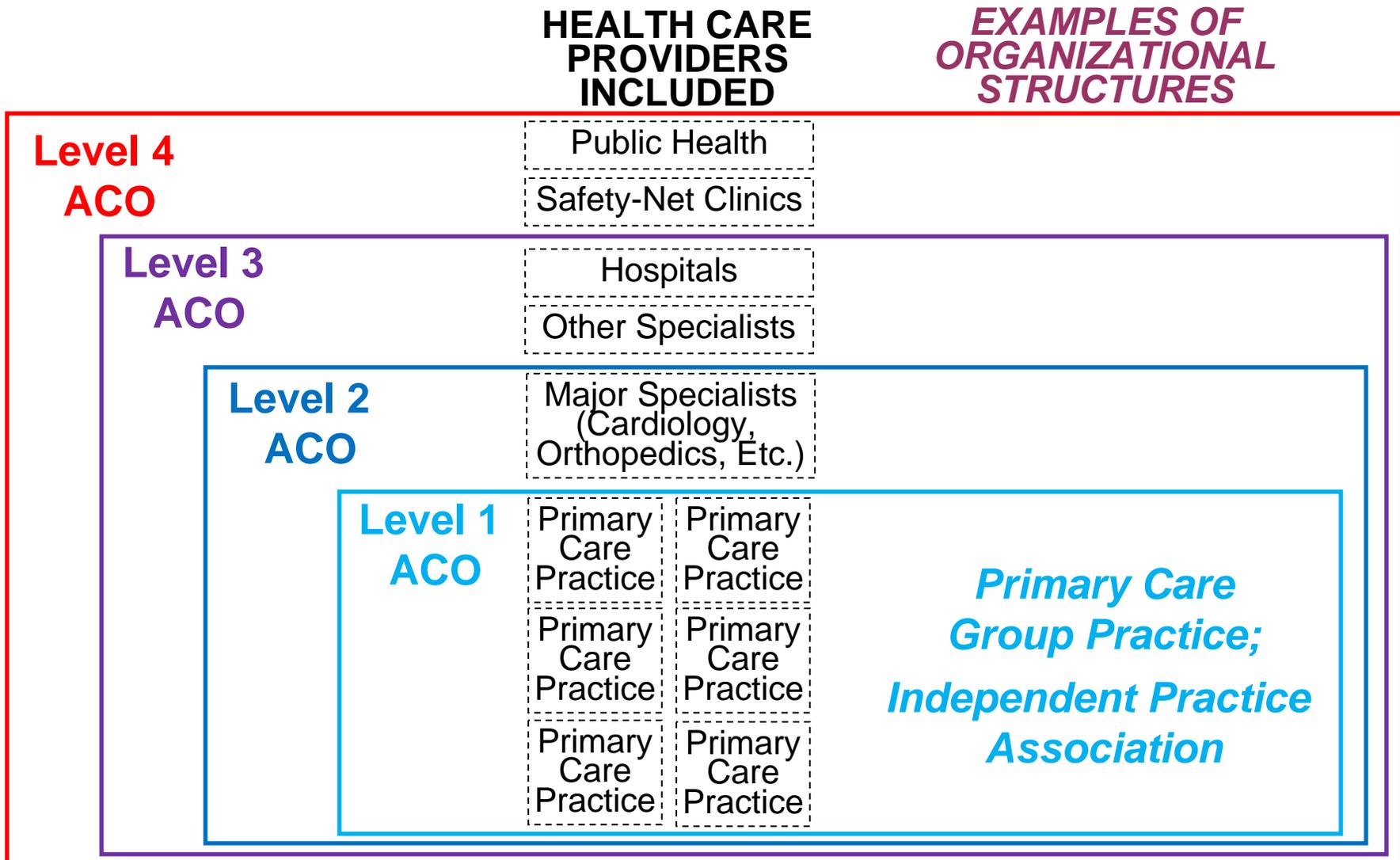


# “Level 4” ACO: Integrated Medical & Social Svcs



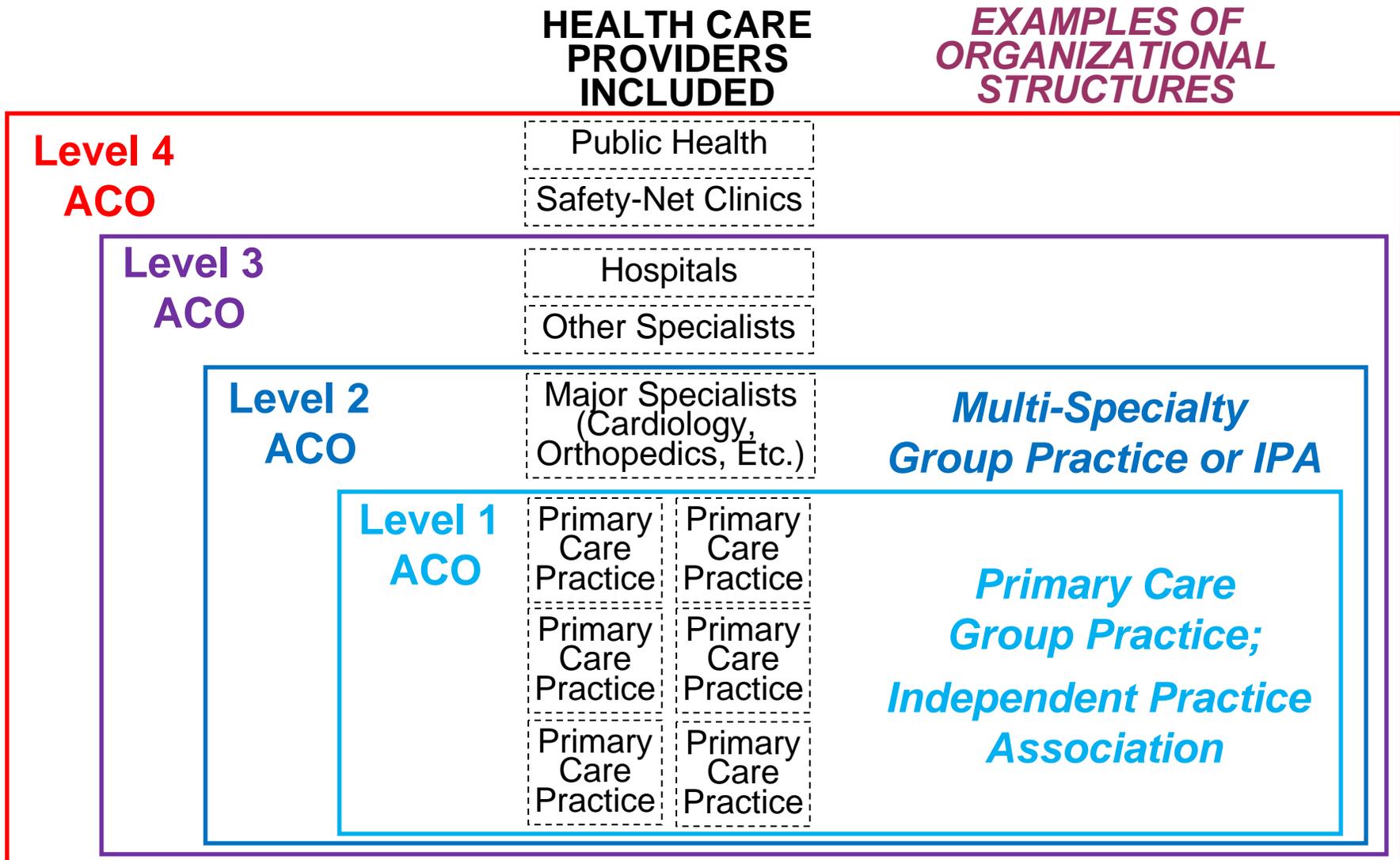


# Organizational Structures to Support Accountable Care



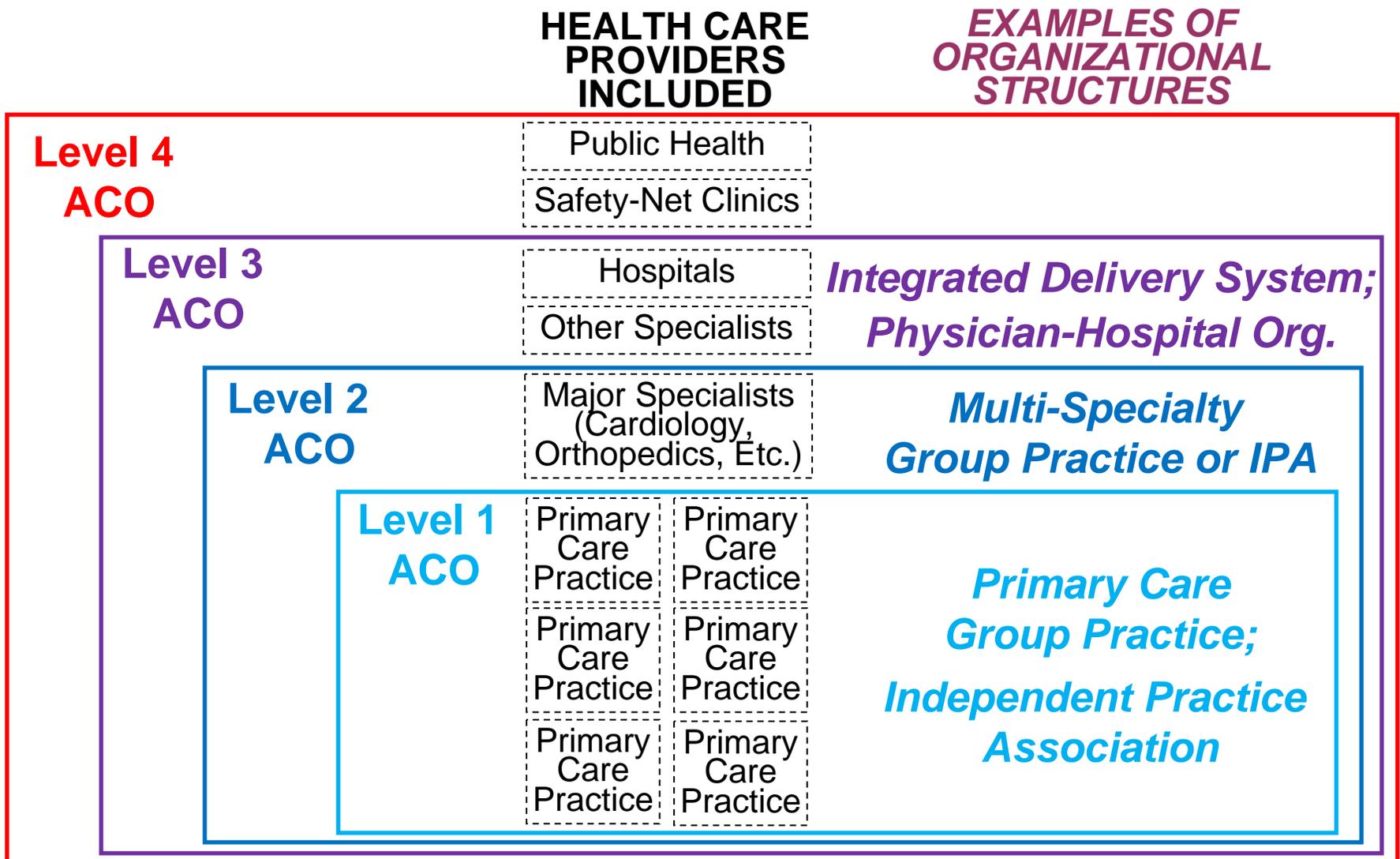


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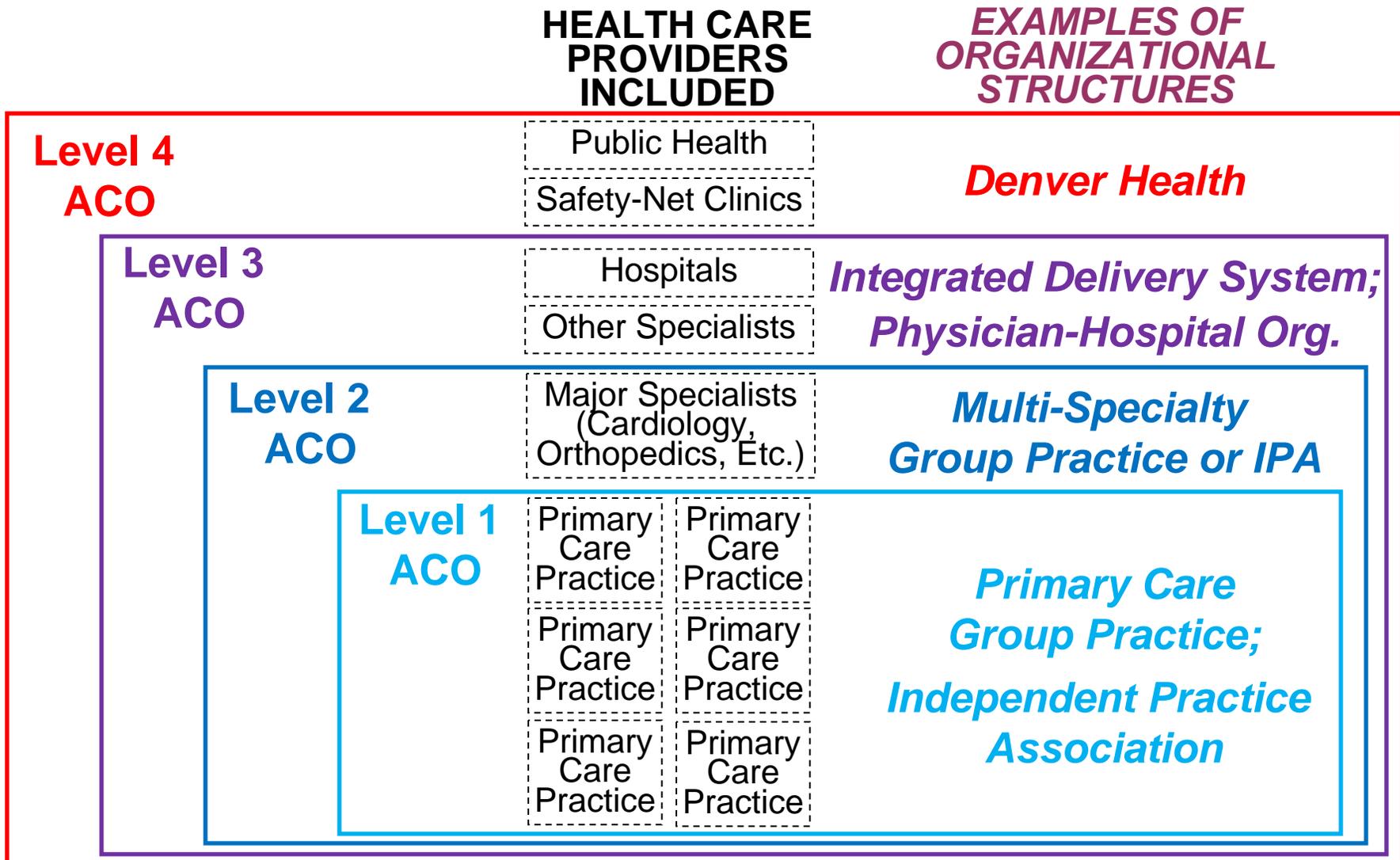


# Organizational Structures to Support Accountable Care





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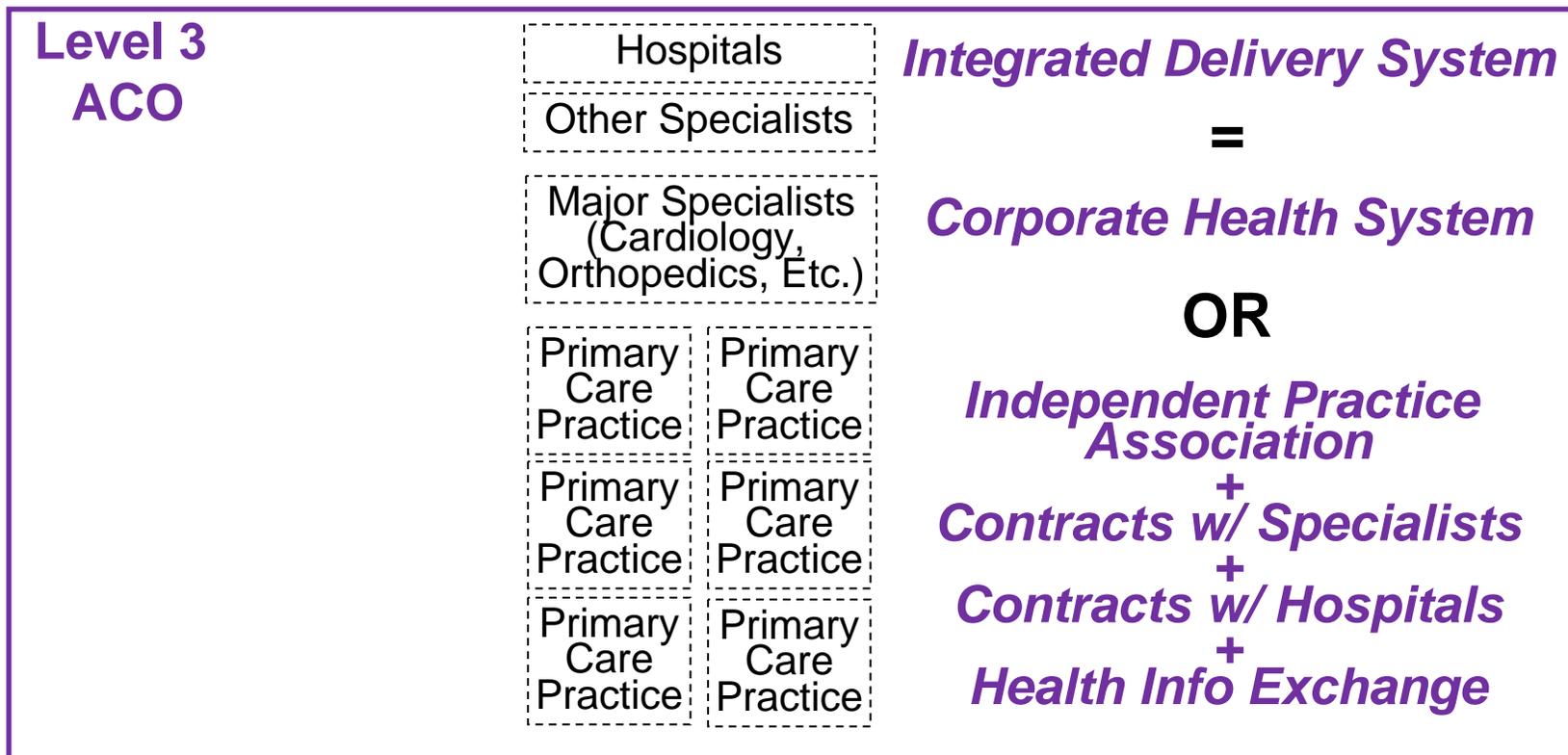




# Key is *Clinical* Integration, Not Corporate Integration

**HEALTH CARE  
PROVIDERS  
INCLUDED**

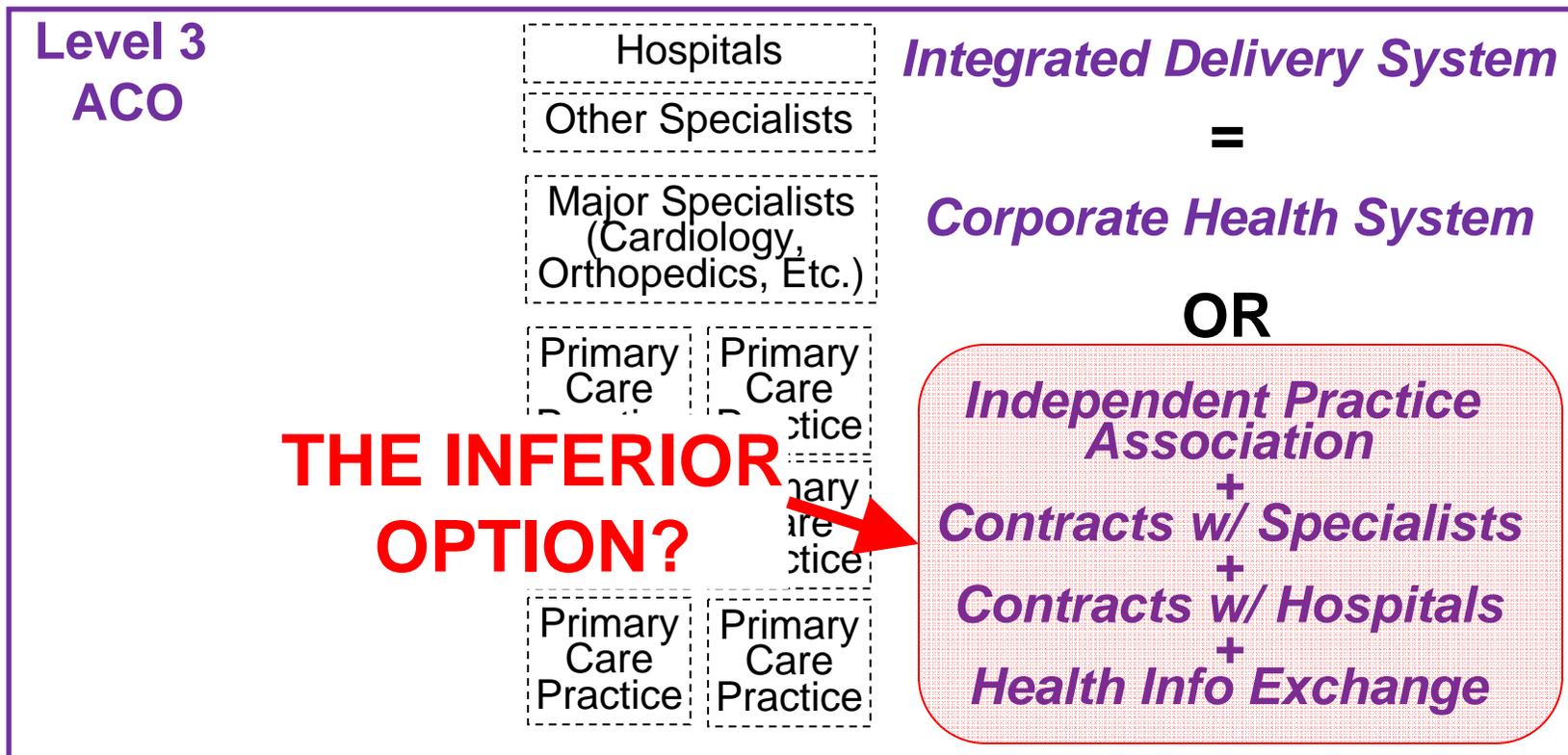
**EXAMPLES OF  
ORGANIZATIONAL  
STRUCTURES**



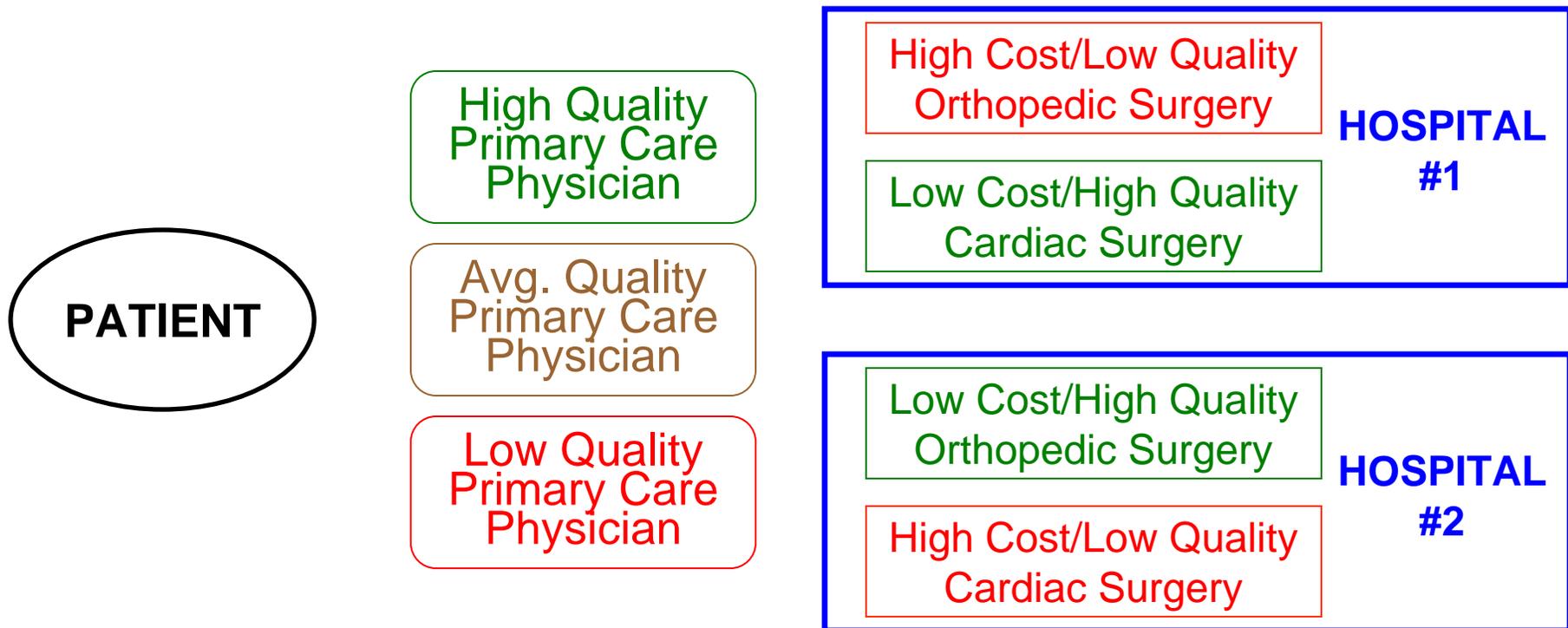
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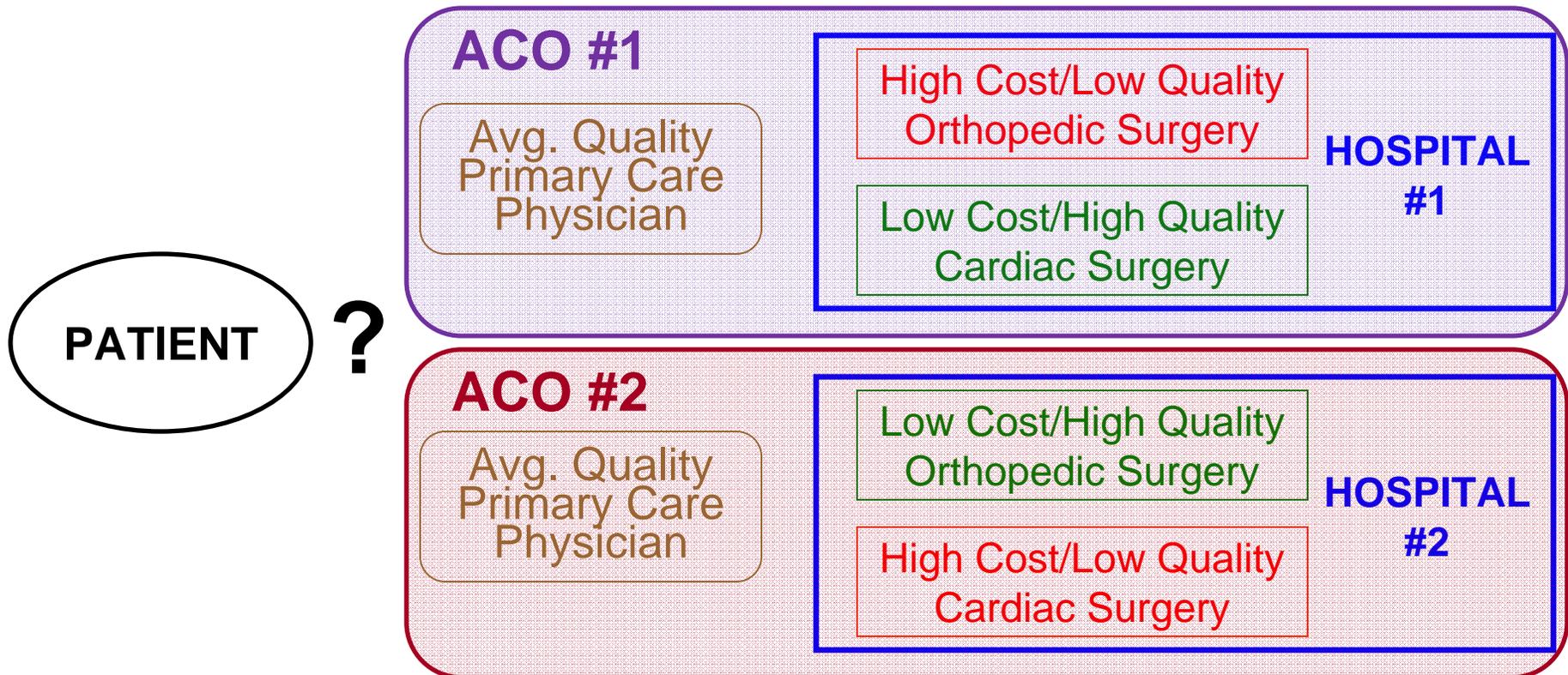
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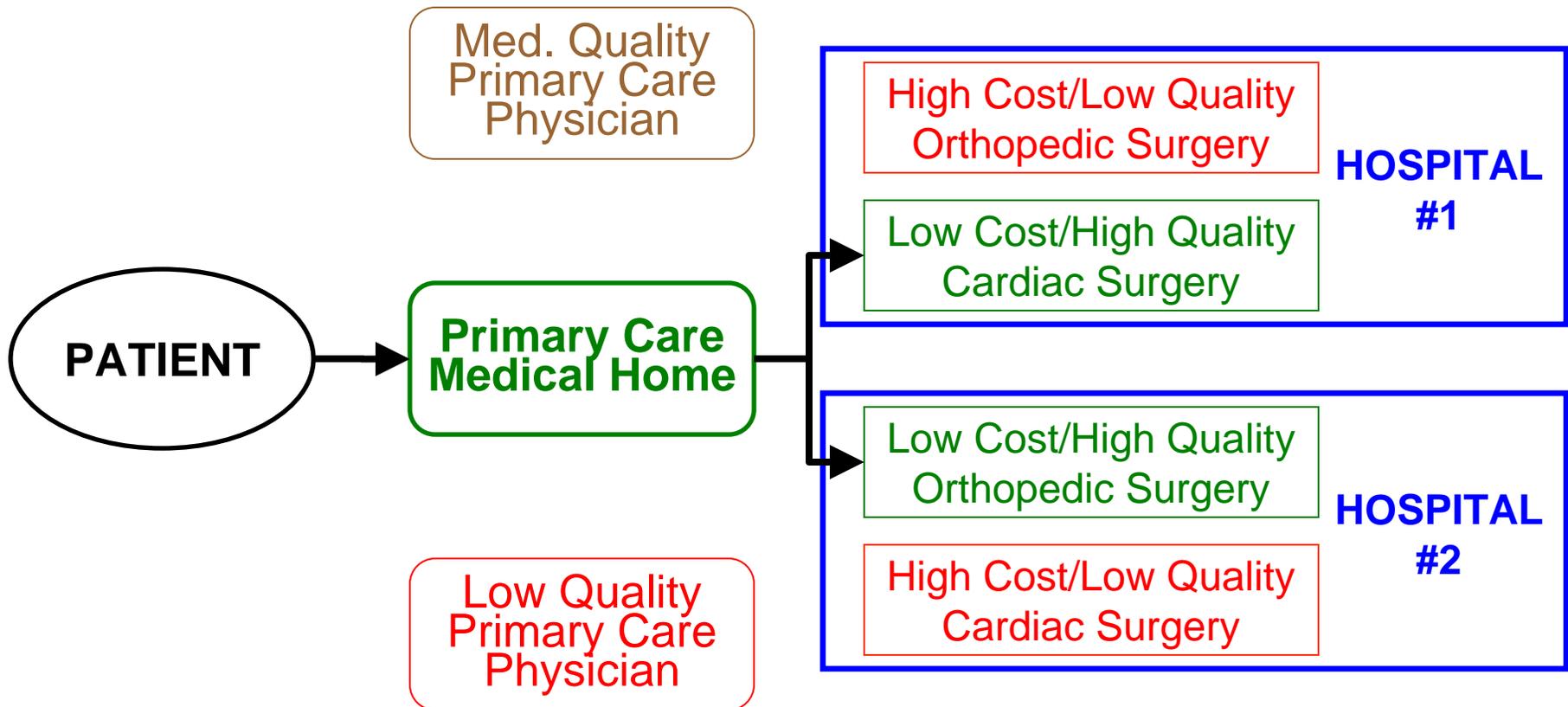
# Looking Through the Patient's (& Purchaser's) Eyes



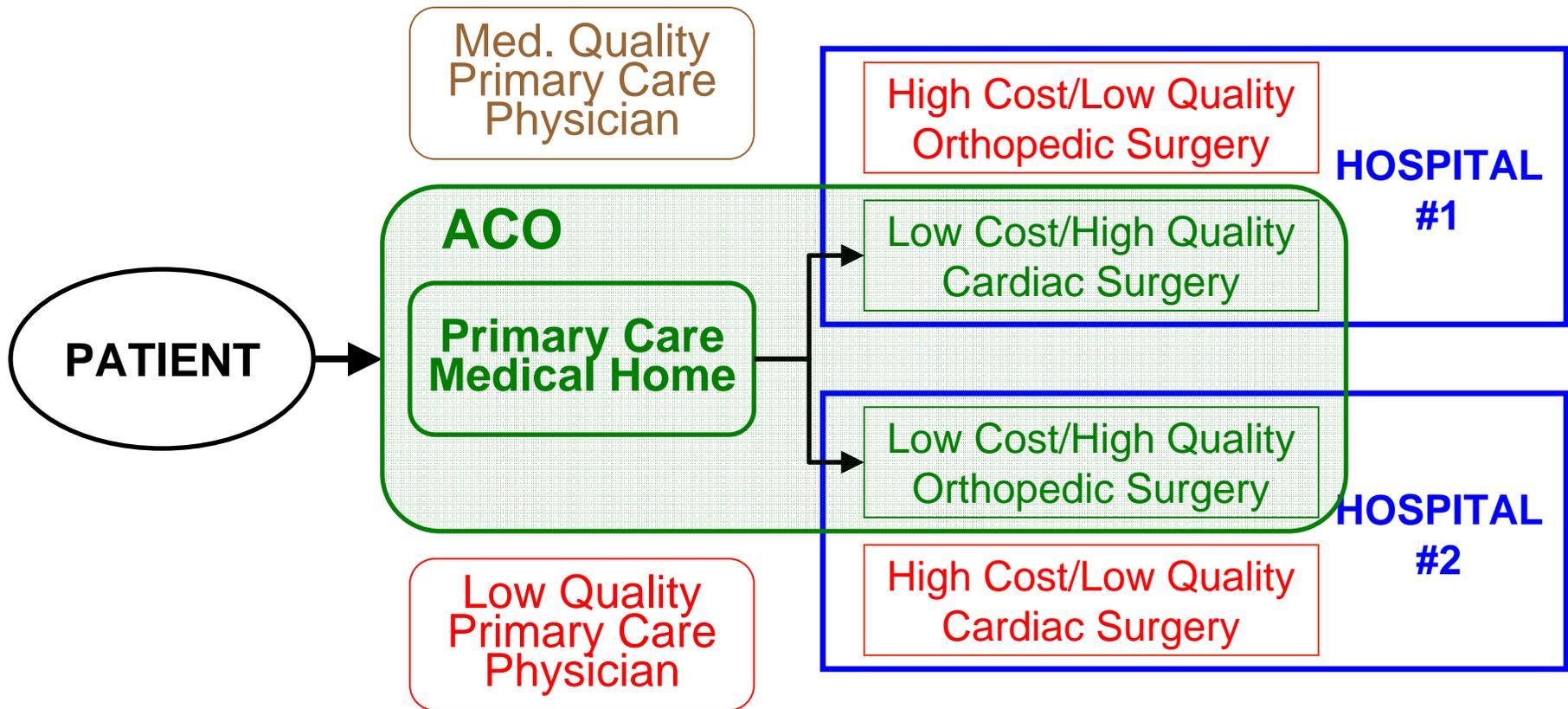
# Who Will Want to Choose Hospital-Centric Networks??



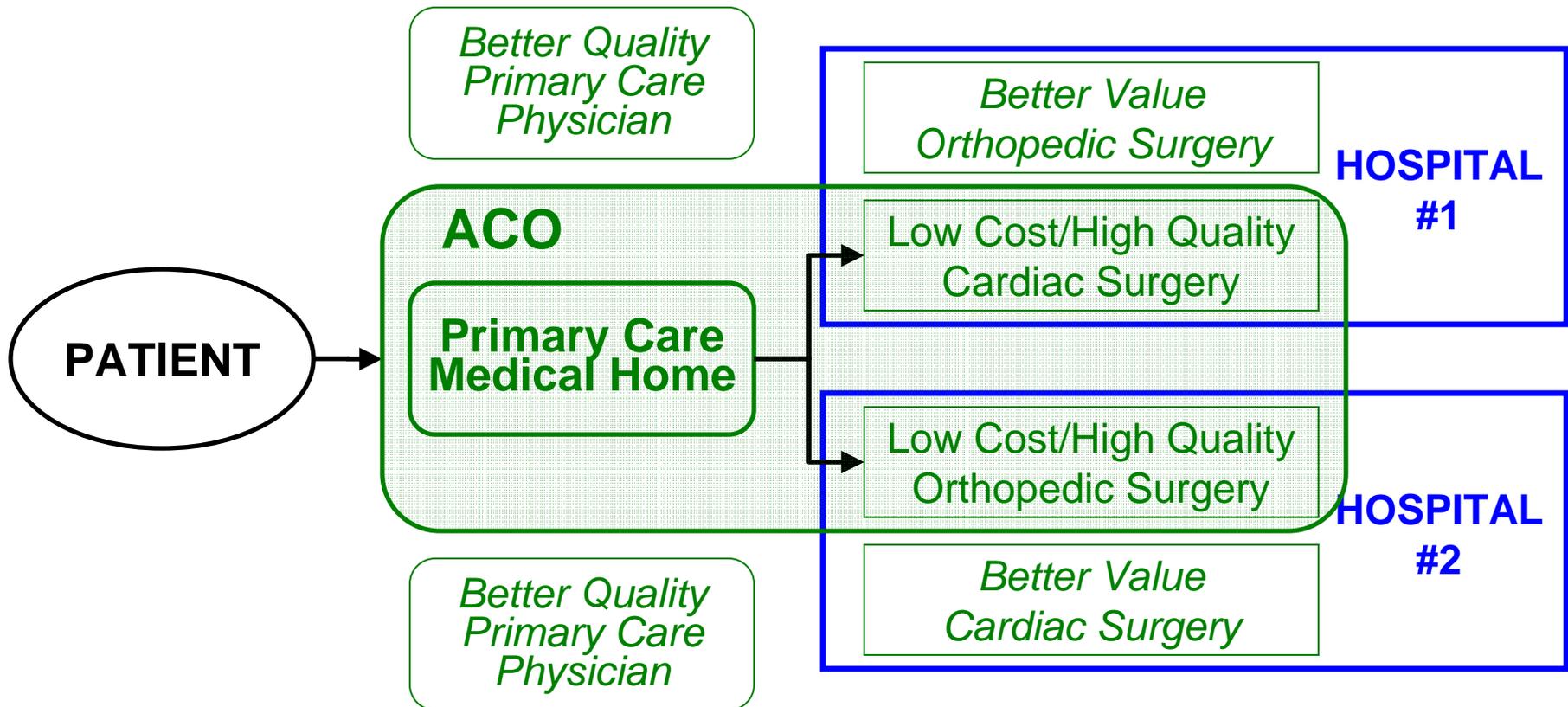
# A Better Solution: Medical Homes + Value-Based Acute Care Choice



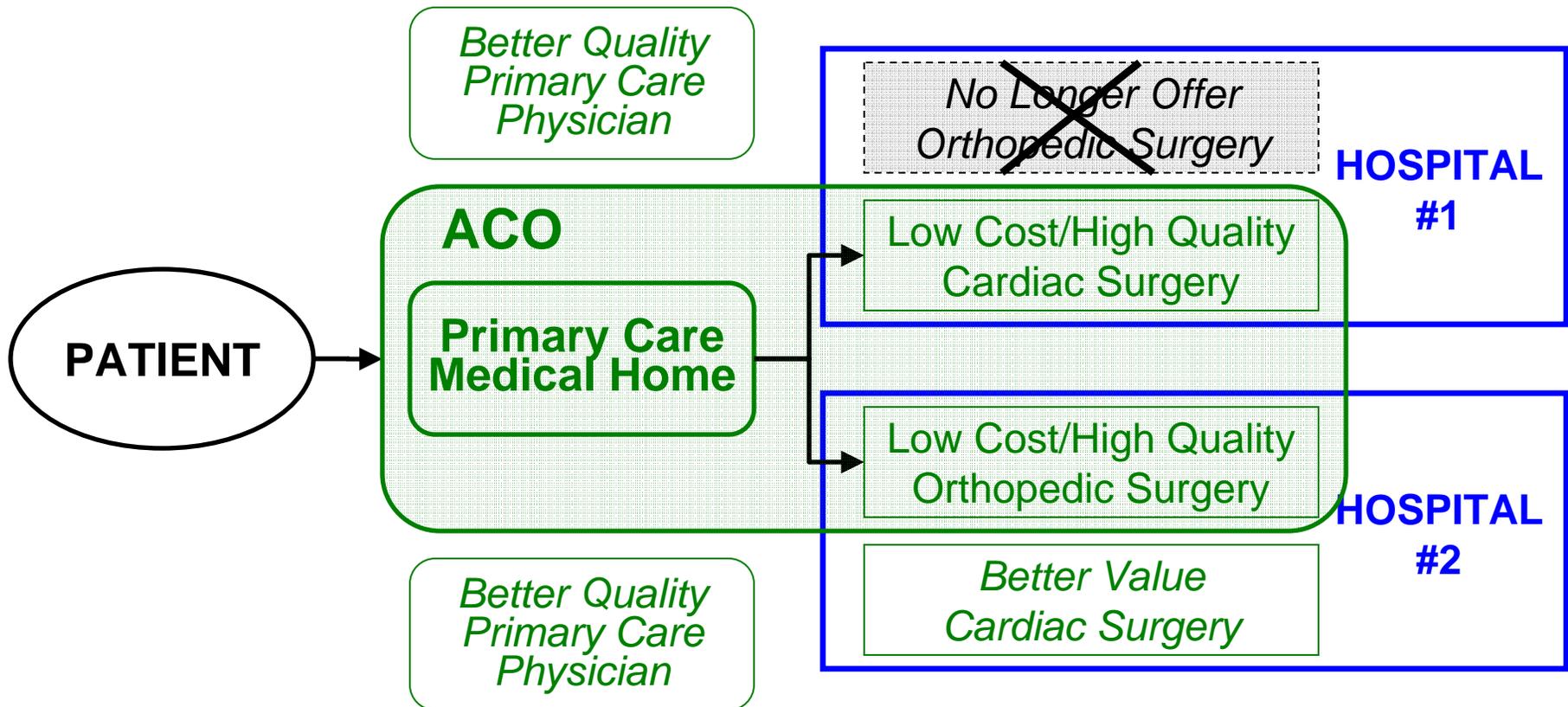
# The Right Way to Define ACOs...



# ...And the Right Way to Stimulate Improvement In Other Services...

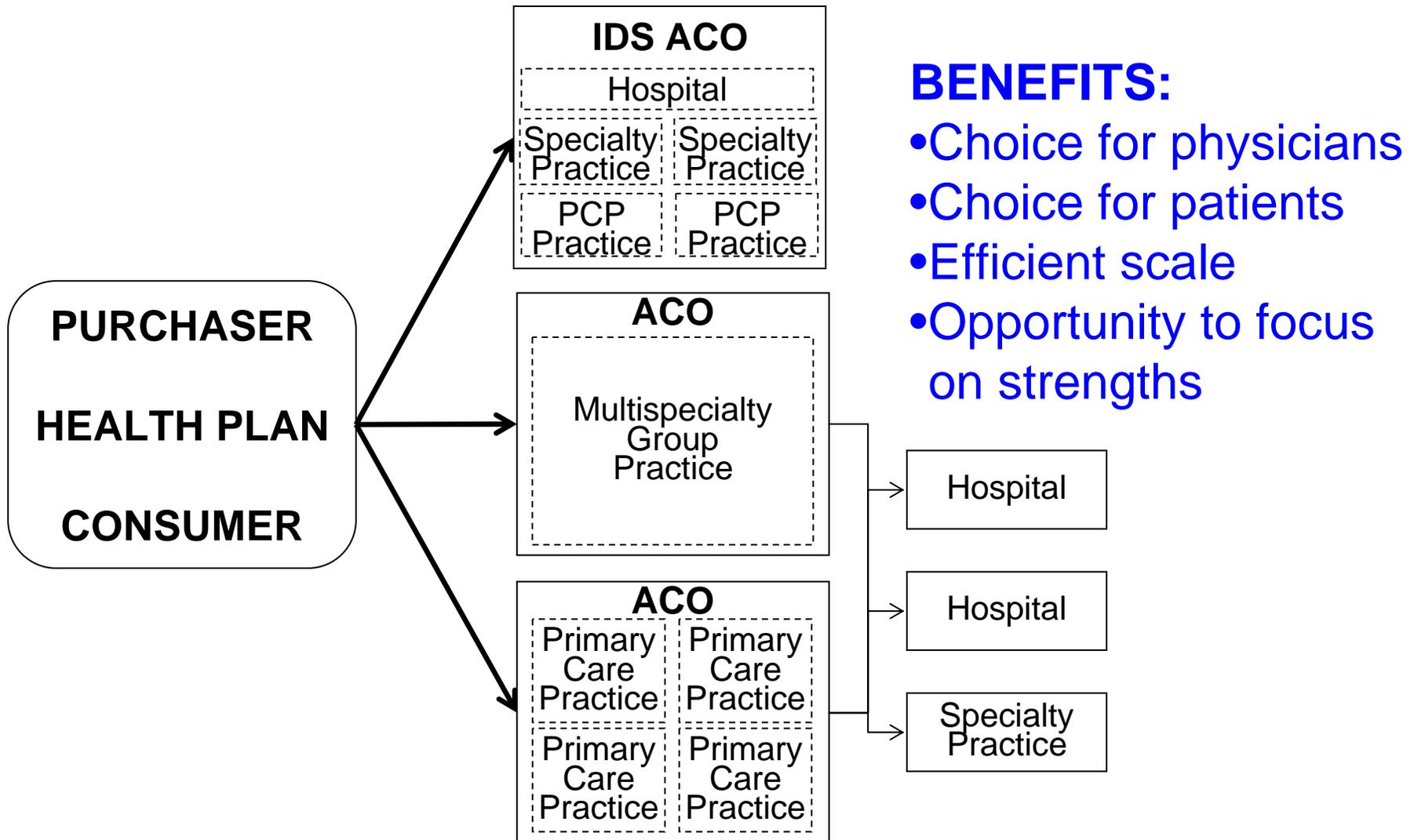


# ...Or See Low Quality Services Disappear



# How Many ACOs in a Region?

## Multiple, “Right-Sized” ACOs

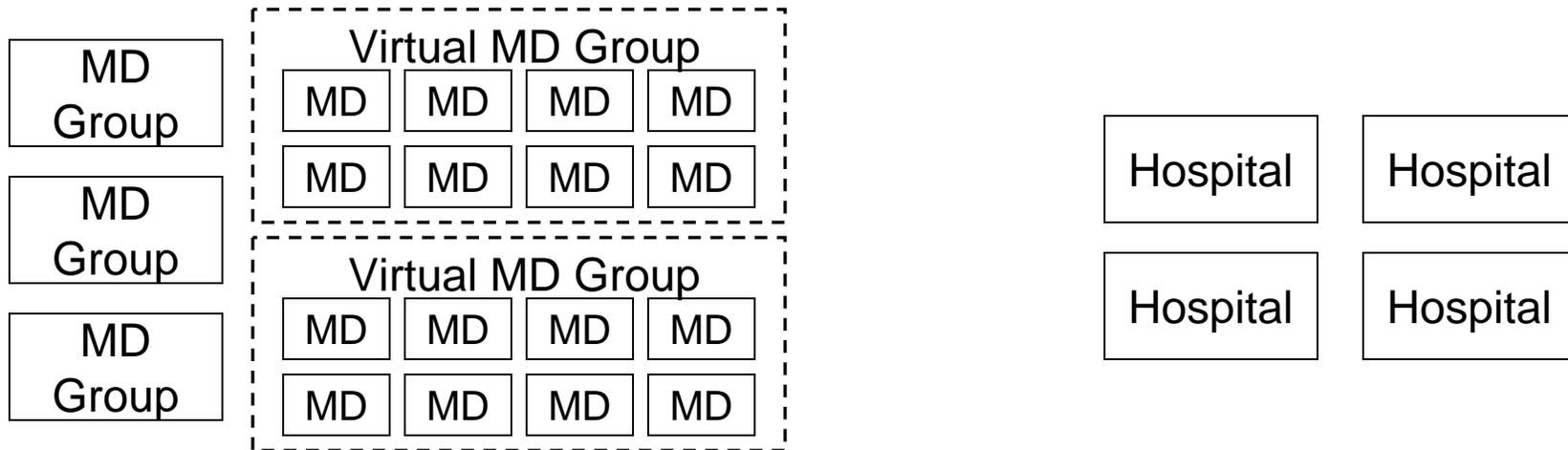


### BENEFITS:

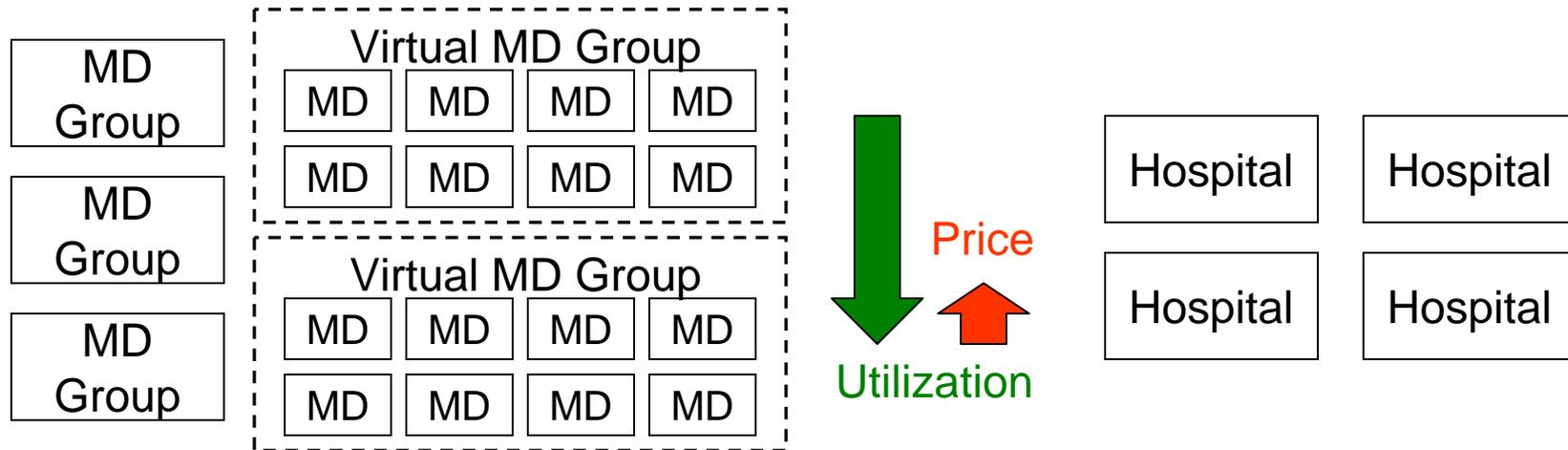
- Choice for physicians
- Choice for patients
- Efficient scale
- Opportunity to focus on strengths



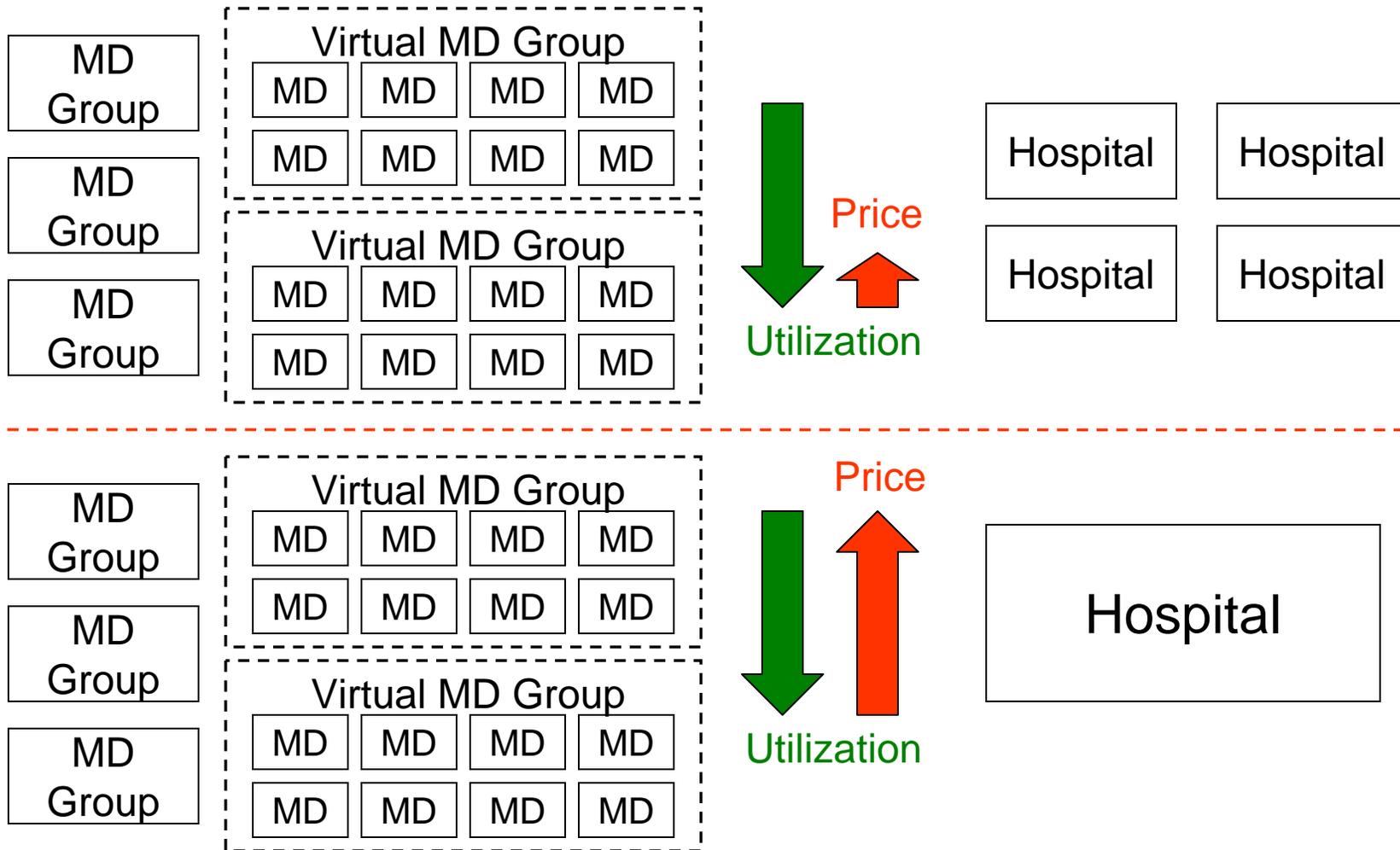
# Hospital Market Structure Key to Overall Cost Control



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# Monopoly Hospitals Could Reprice to Offset Utilization





# Our Standard Methods of Controlling Prices Don't Work

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- **Price Negotiations as Part of Contracting**
  - Even large insurers can't demand price concessions from large/monopoly providers



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- **Narrow Networks**
  - In theory, could steer patients to lower-cost providers and give providers greater volume to reduce prices
  - In practice, prohibits patients from using the providers they prefer and creates consumer backlash
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- **Copays, Co-insurance and High-Deductible Health Plans**
  - Create little incentive for consumers to choose lower-cost providers on the expensive items that make a difference
  - Create significant disincentive to pursue preventive care that may prevent the expensive items in the first place

# Your Choices With Auto Purchase Insurance

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## HYUNDAI SONATA



5 yr/60,000m warranty  
5 star crash rating

**MSRP: \$22,450**

## LEXUS LS 460



4 yr/50,000m warranty  
No crash rating

**MSRP: \$63,825**

# Copayment: Lexus Wins

## HYUNDAI SONATA



5 yr/60,000m warranty  
5 star crash rating

**MSRP: \$22,450**

**\$1,000 Copay:**

**\$1,000**

## LEXUS LS 460



4 yr/50,000m warranty  
No crash rating

**MSRP: \$63,825**

**\$1,000✓**

# Coinsurance: Lexus Wins for Most People

## HYUNDAI SONATA



5 yr/60,000m warranty  
5 star crash rating

**MSRP: \$22,450**

**\$1,000 Copay: \$1,000**

**10% Coinsurance: \$2,245**

## LEXUS LS 460



4 yr/50,000m warranty  
No crash rating

**MSRP: \$63,825**

**\$1,000 ✓**

**\$6,383 ✓**

# High Deductible: Lexus Wins

## HYUNDAI SONATA



5 yr/60,000m warranty  
5 star crash rating

**MSRP: \$22,450**

**\$1,000 Copay:** **\$1,000**

**10% Coinsurance:** **\$2,245**

**High Deductible:** **\$10,000**

## LEXUS LS 460



4 yr/50,000m warranty  
No crash rating

**MSRP: \$63,825**

**\$1,000** ✓

**\$6,383** ✓

**\$10,000** ✓

# Price Difference: Hyundai Wins for Most People

## HYUNDAI SONATA



5 yr/60,000m warranty  
5 star crash rating

**MSRP: \$22,450**

**\$1,000 Copay:** **\$1,000**

**10% Coinsurance:** **\$2,245**

**High Deductible:** **\$10,000**

**Price Difference:** **\$0 ✓**

## LEXUS LS 460



4 yr/50,000m warranty  
No crash rating

**MSRP: \$63,825**

**\$1,000 ✓**

**\$6,383 ✓**

**\$10,000 ✓**

**\$41,375**



# Better Ways of Controlling Prices

---

- **Value-Based Competition by Providers for Consumers**
  - Define episode prices and global fees so it's easier to compare costs of different providers and procedures
  - Publish information on prices and quality of all providers
  - Require consumers to pay the “last dollar” of providers’ prices (i.e., the difference between the prices of more expensive and less expensive providers/services with equivalent quality)
  - Create shared decision-making processes to help consumers decide among services based on benefits and costs

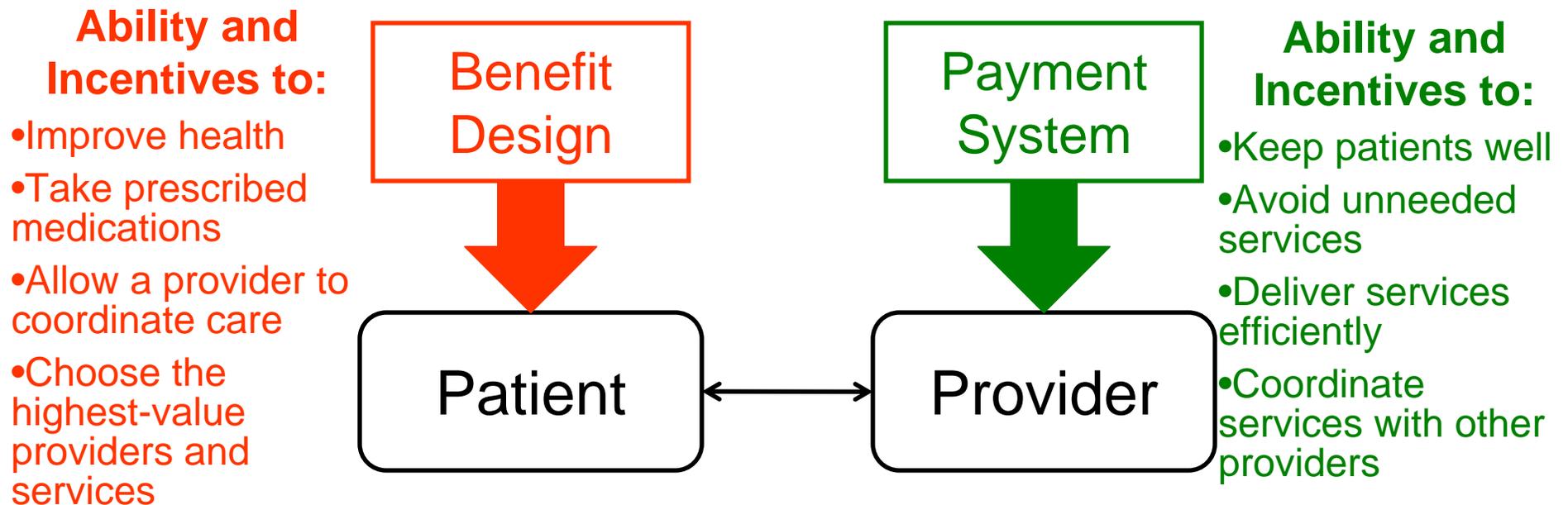


# Better Ways of Controlling Prices

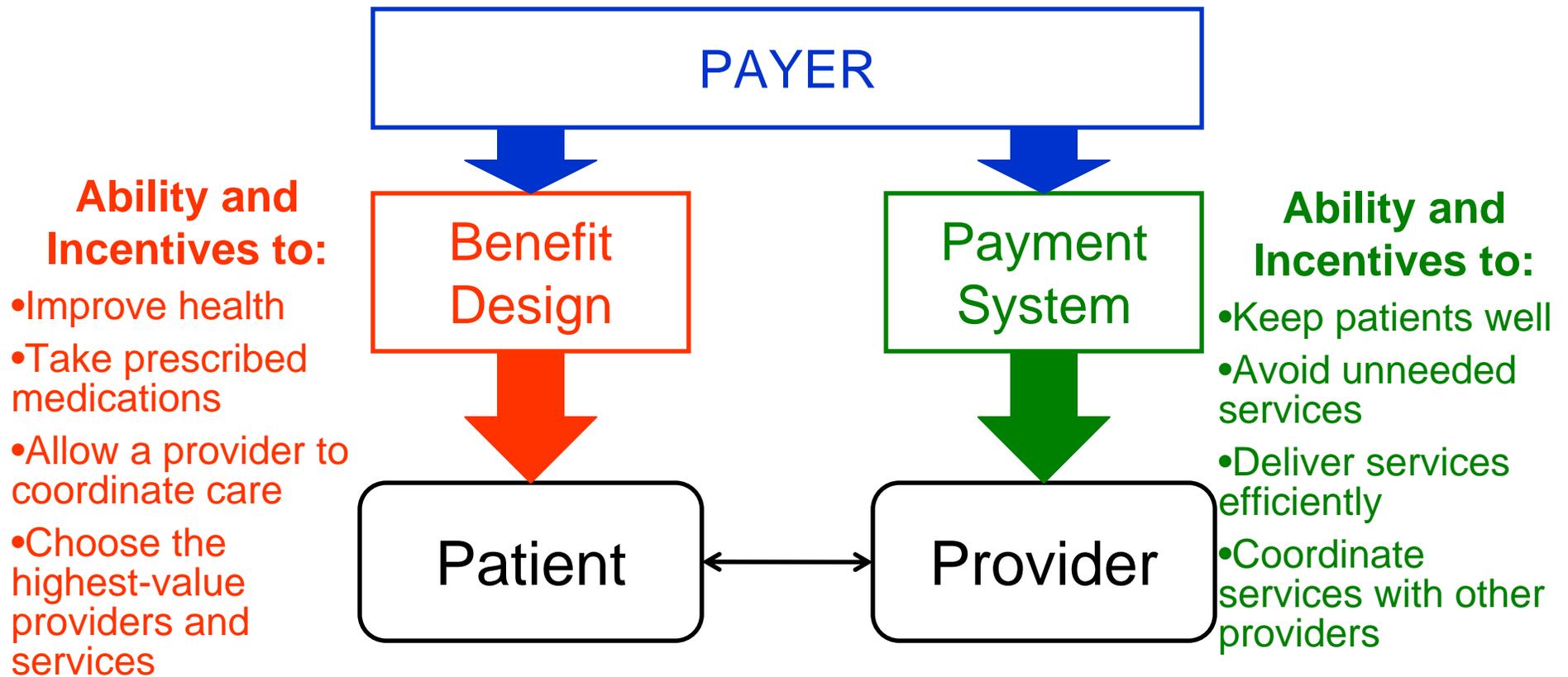
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  - Create shared decision-making processes to help consumers decide among services based on benefits and costs
- **Ensuring There Are Competitors**
  - Prevent anti-competitive consolidations and encourage limited duplication of services (assuming consumers are made price-sensitive)
  - Regulate prices where monopolies exist (e.g., the Maryland Hospital rate-setting commission)
  - Prohibit all-or-nothing contracting for services by large health providers as a condition of tax exemption

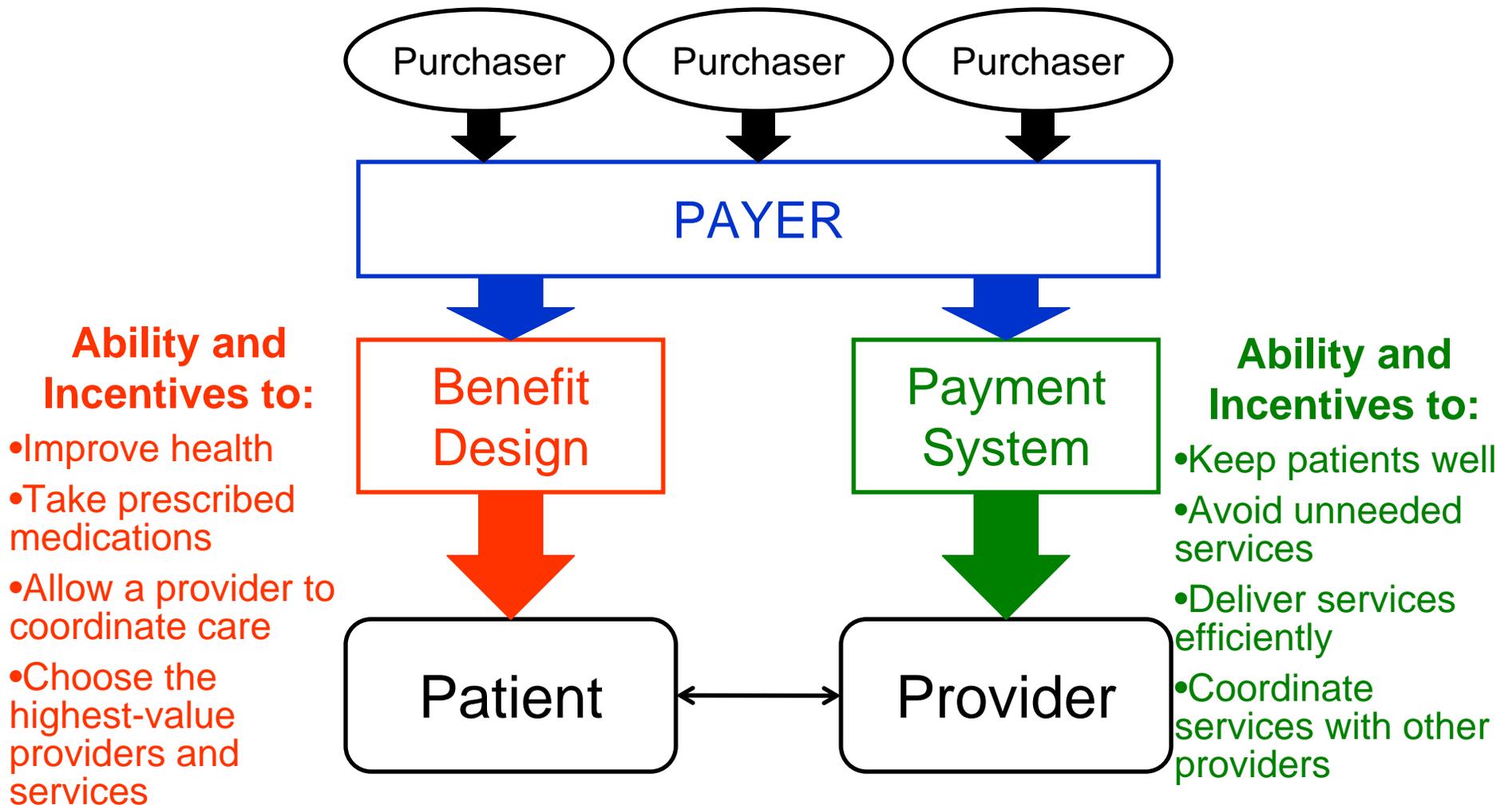
# Benefit Design Changes Are Also Critical to Success



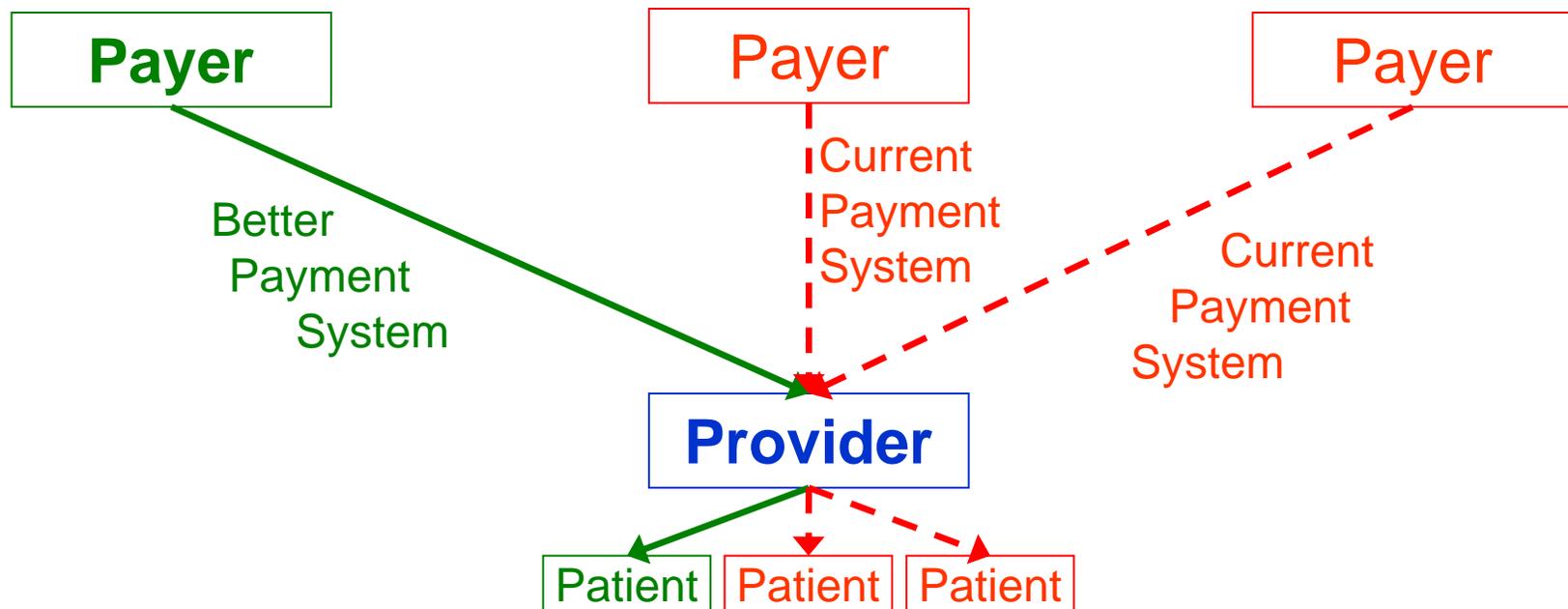
# Both are Controlled by the Payer



# But Purchaser Support is Needed Particularly for Benefit Changes

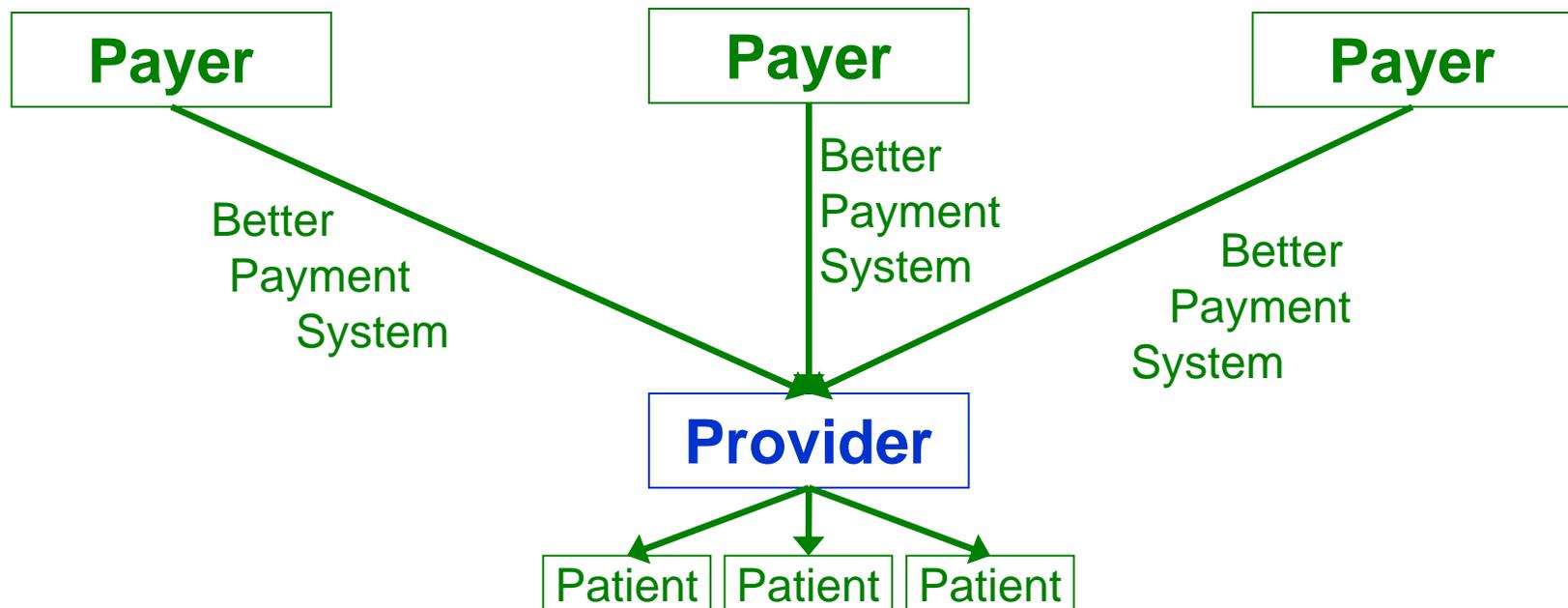


# One Payer Changing Isn't Enough

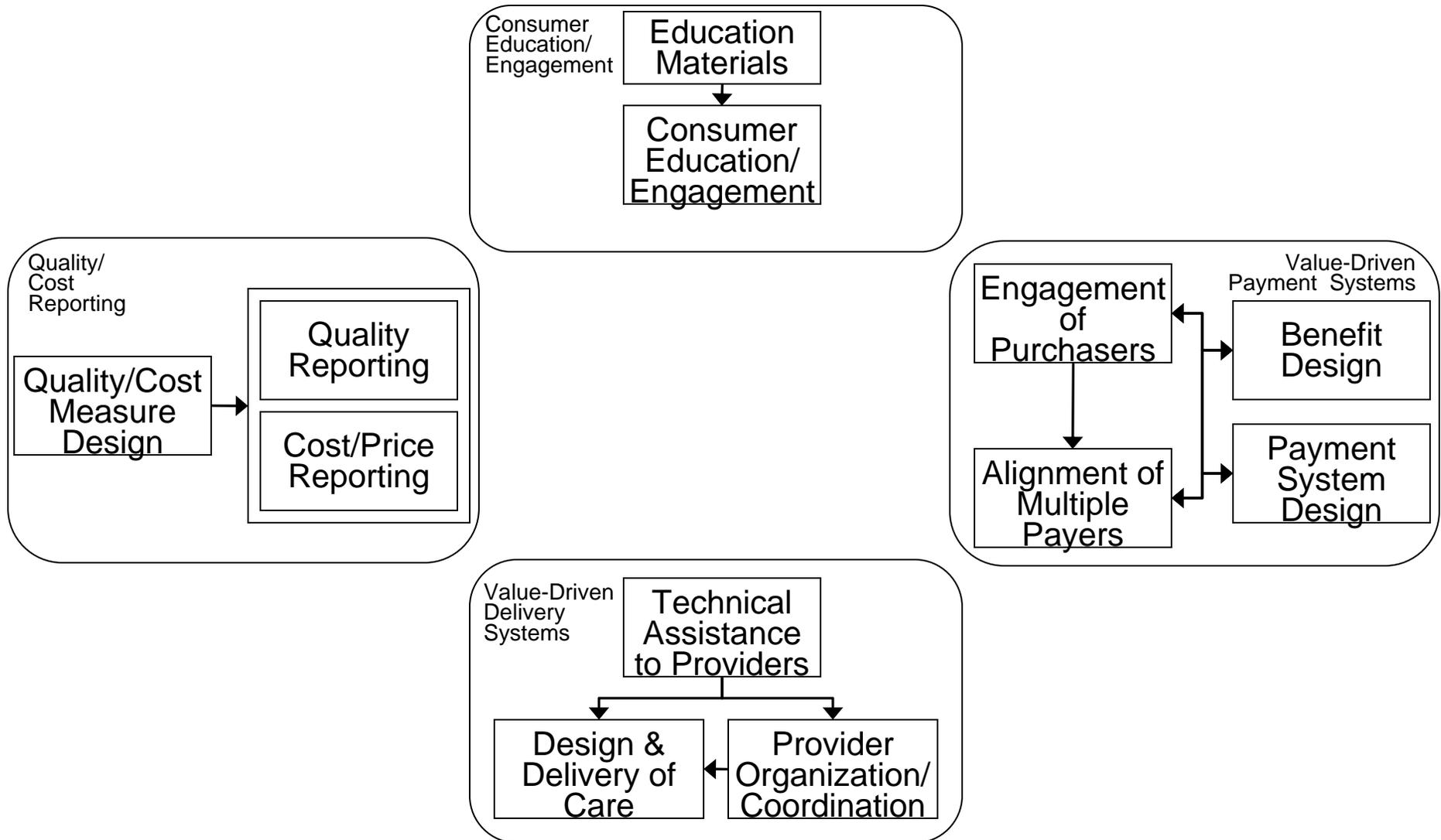


***Provider is only compensated for changed practices for the subset of patients covered by participating payers***

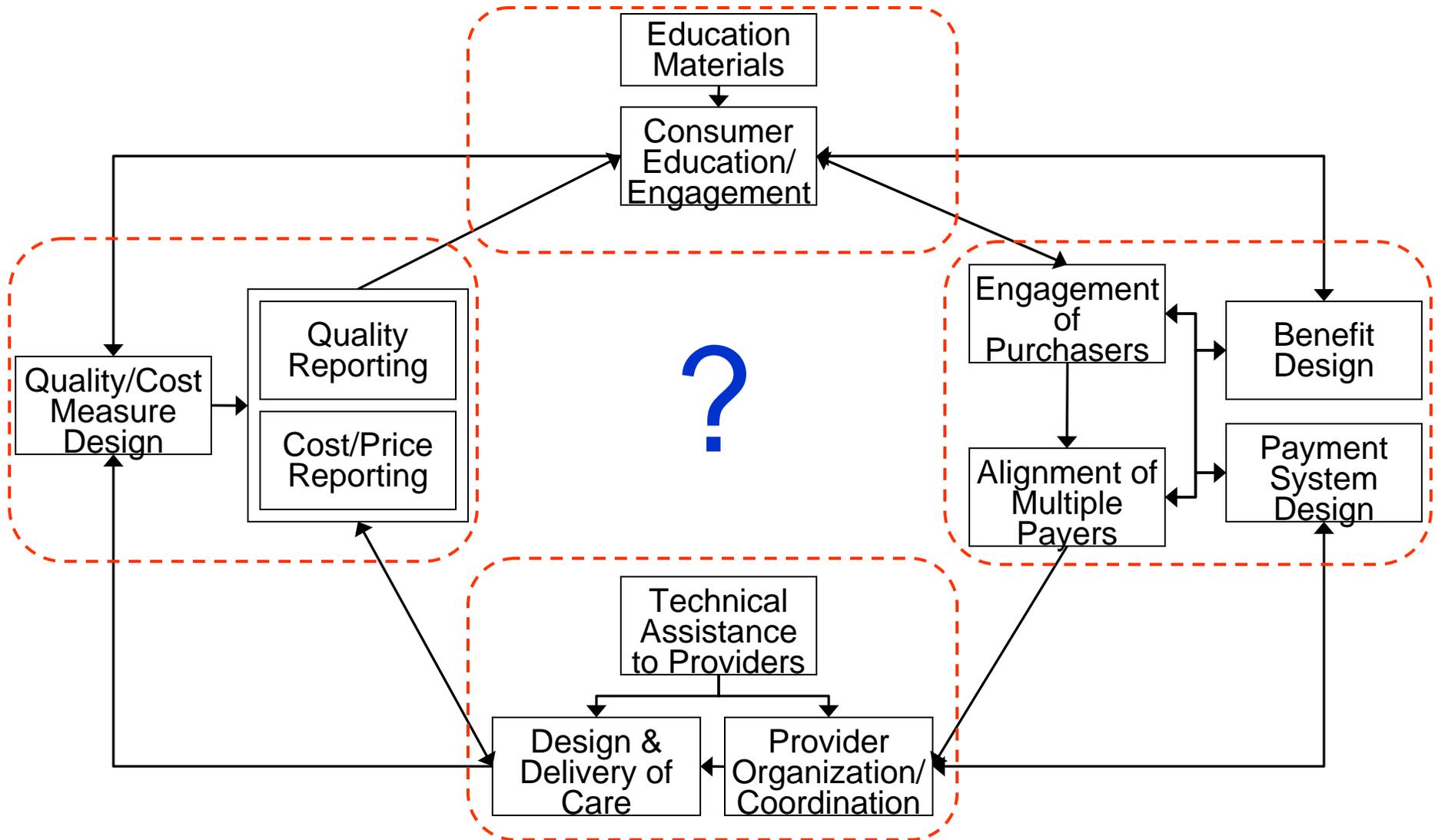
# Payers Need to Align to Enable Providers to Transform



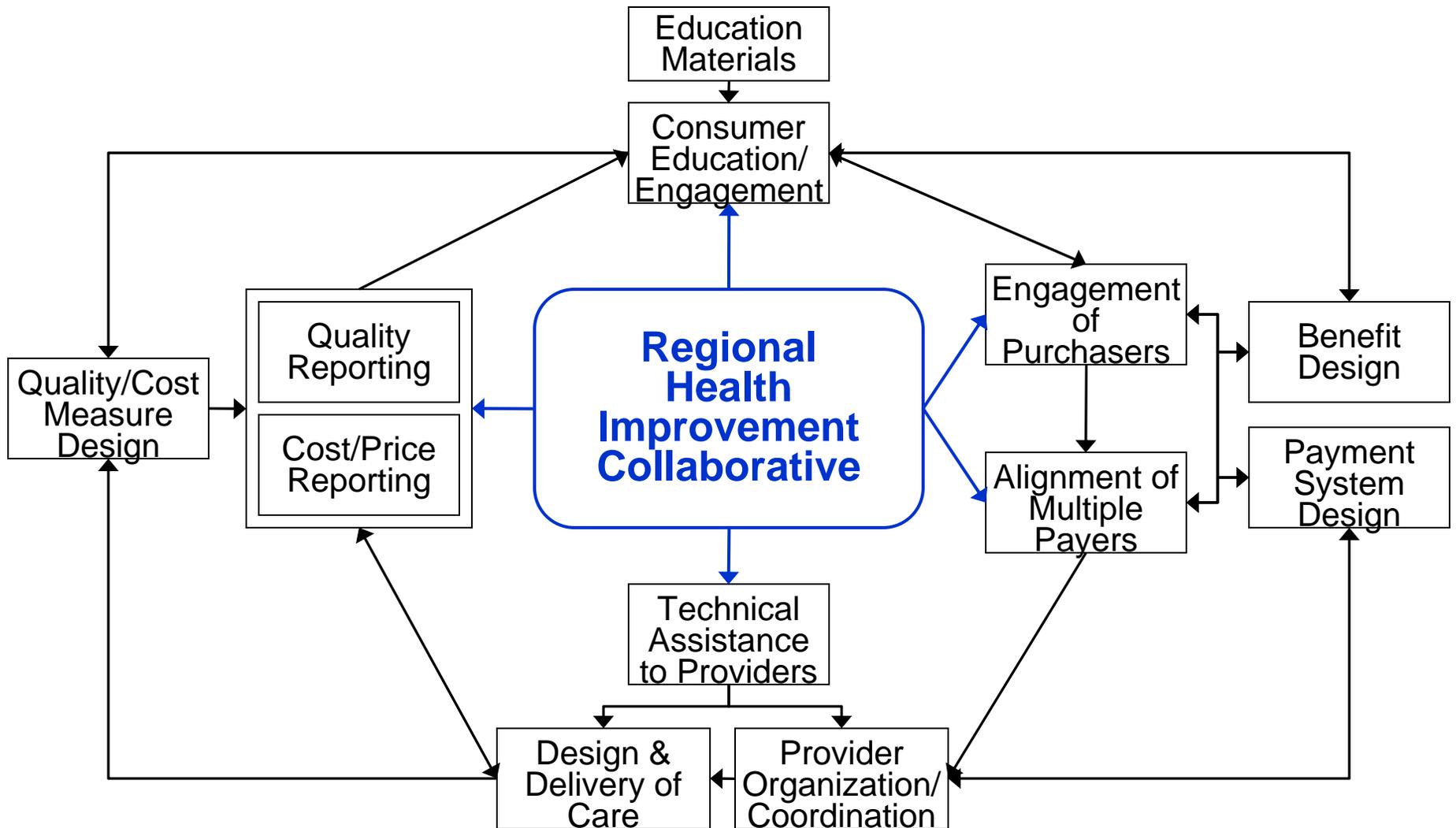
# Functions Needed for Healthcare Reform in A Region



# Functions Can't Proceed in Silos

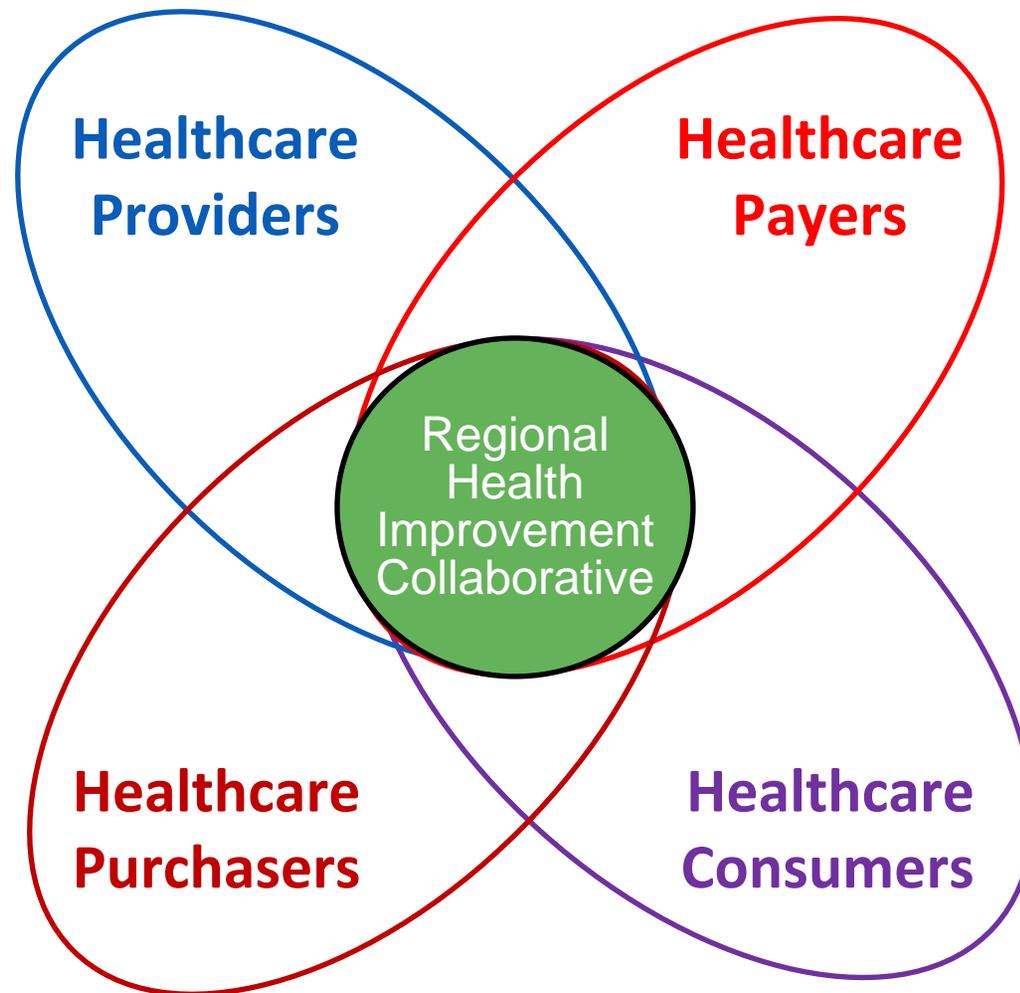


# Coordinated Support for All Functions at the Regional Level



# ...With Active Involvement of All Healthcare Stakeholders

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# For More Information:

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[www.CHQPR.org](http://www.CHQPR.org)

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