Moving Toward Accountable Care: "It's Not (Merely) About the Bike"

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“It’s Not About the Bike”

"It's Not (Merely) About the Bike"

Care processes

People and organizations

Information systems

…in an environment in which health IT and payment models increase value and lower improvement costs

Care Processes

- Sharing a vision for optimal care
- Designing end-to-end care processes
- Fitting processes to patients

<u>Example questions</u>: What is optimal diabetes care? Who gets the post-discharge home visit? Which patients are targeted for adherence programs? Which patients are targeted by panel managers?

People and Organizations

- Fitting processes to knowledge, skills, incentives, and licensure

- Clarifying organizational roles

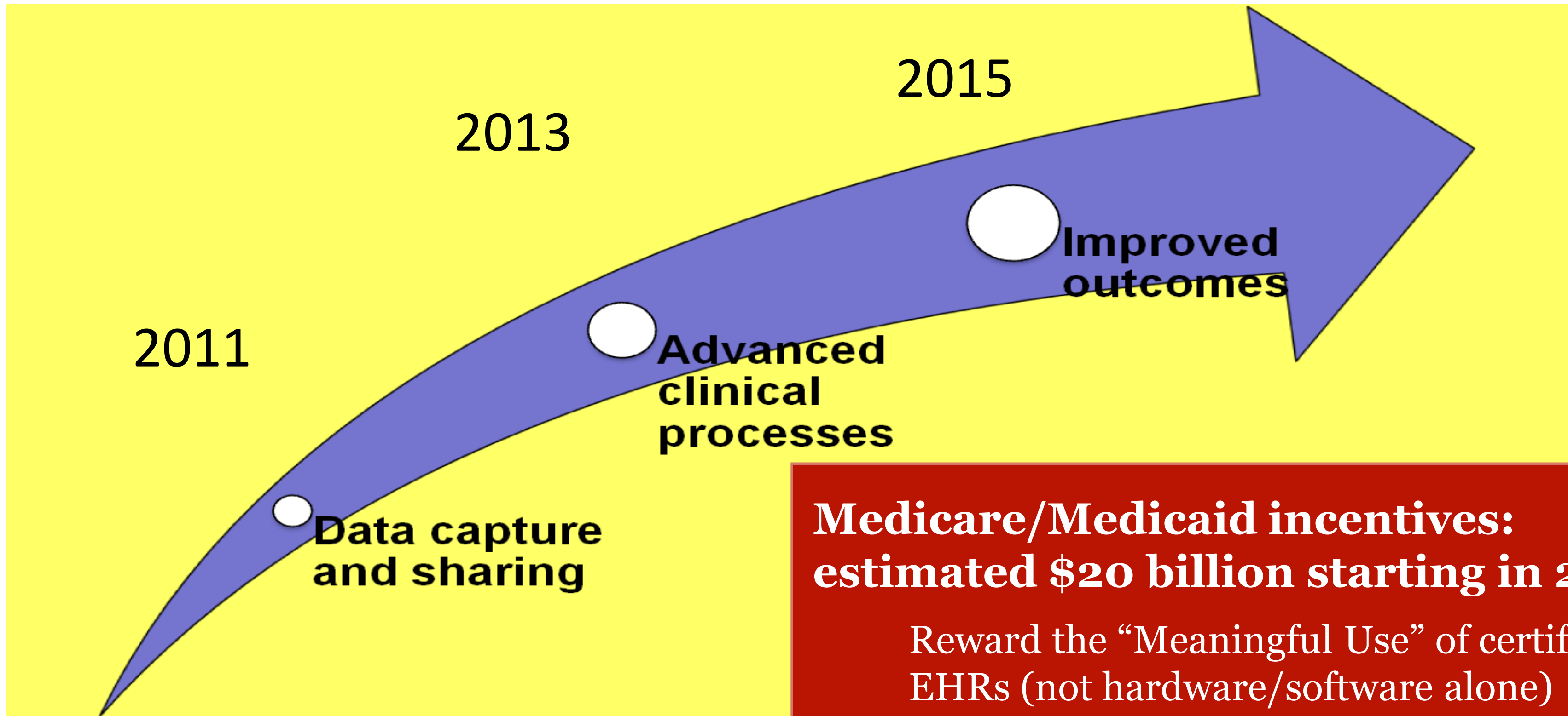
Example questions: What role should health information organizations play A) at the local/proximal level, B) at the population level?

Information Systems

- Fitting IT to the patient's team & processes
- Reporting process status and patient outcomes internally (near-real time)
- Using analytics to fit interventions to those most likely to benefit

Examples: Tulsa Beacon Community, NC Beacon Community

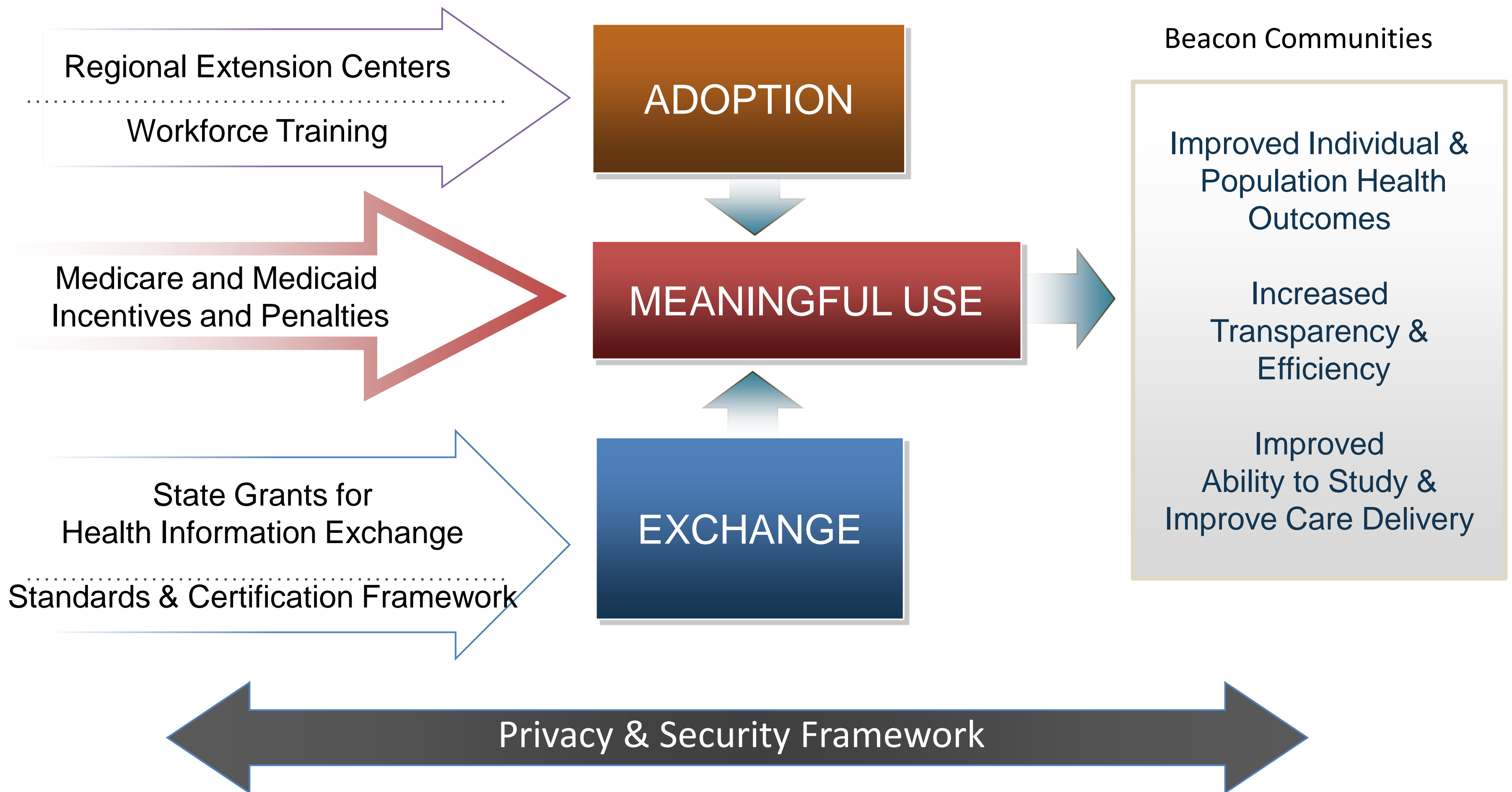
Meaningful Use Establishes a "Floor" for Improvement



Medicare/Medicaid incentives: estimated $20 billion starting in 2011

- Reward the "Meaningful Use" of certified EHRs (not hardware/software alone)
- Physicians: $44,000/$63,750, with penalties starting in 2015
- Hospitals: $2M plus bonuses for higher Medicare, Medicaid volume
- Escalating requirements – 2011, 2013, 2015

A Framework to Advance Meaningful Use



EHRs and Care Quality

The NEW ENGLAND JOURNAL of MEDICINE

SPECIAL ARTICLE

Electronic Health Records and Quality of Diabetes Care

Randall D. Cebul, M.D., Thomas E. Love, Ph.D., Anil K. Jain, M.D., and Christopher J. Hebert, M.D.

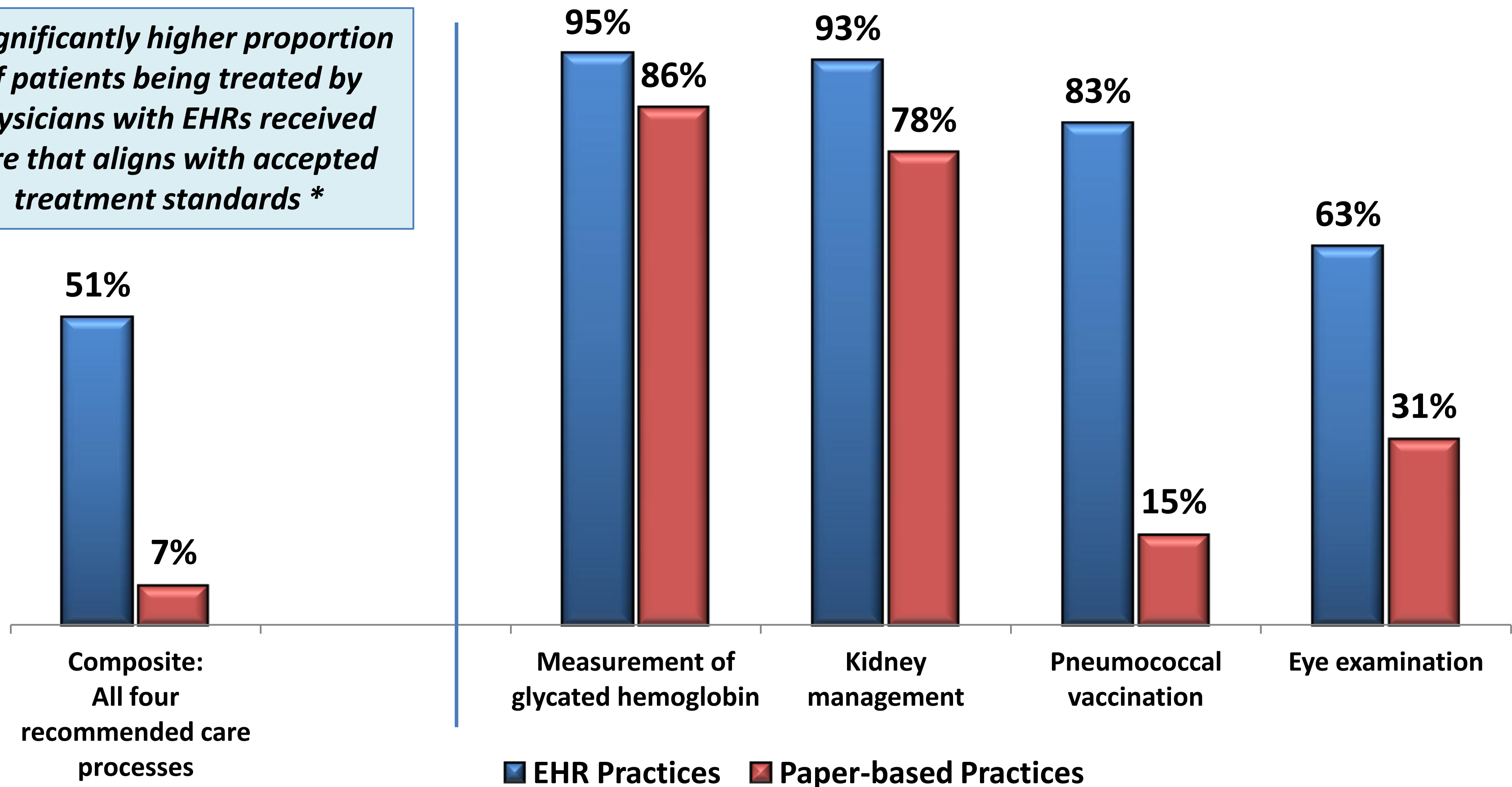
ABSTRACT

BACKGROUND

Available studies have shown few quality-related advantages of electronic health records (EHRs) over traditional paper records. We compared achievement of and improvement in quality standards for diabetes at practices using EHRs with those at practices using paper records. All practices, including many safety-net primary care practices, belonged to a regional quality collaborative and publicly reported performance.

Quality of Diabetes Care:
Patients Treated by Physicians using EHR vs. Paper Medical Records

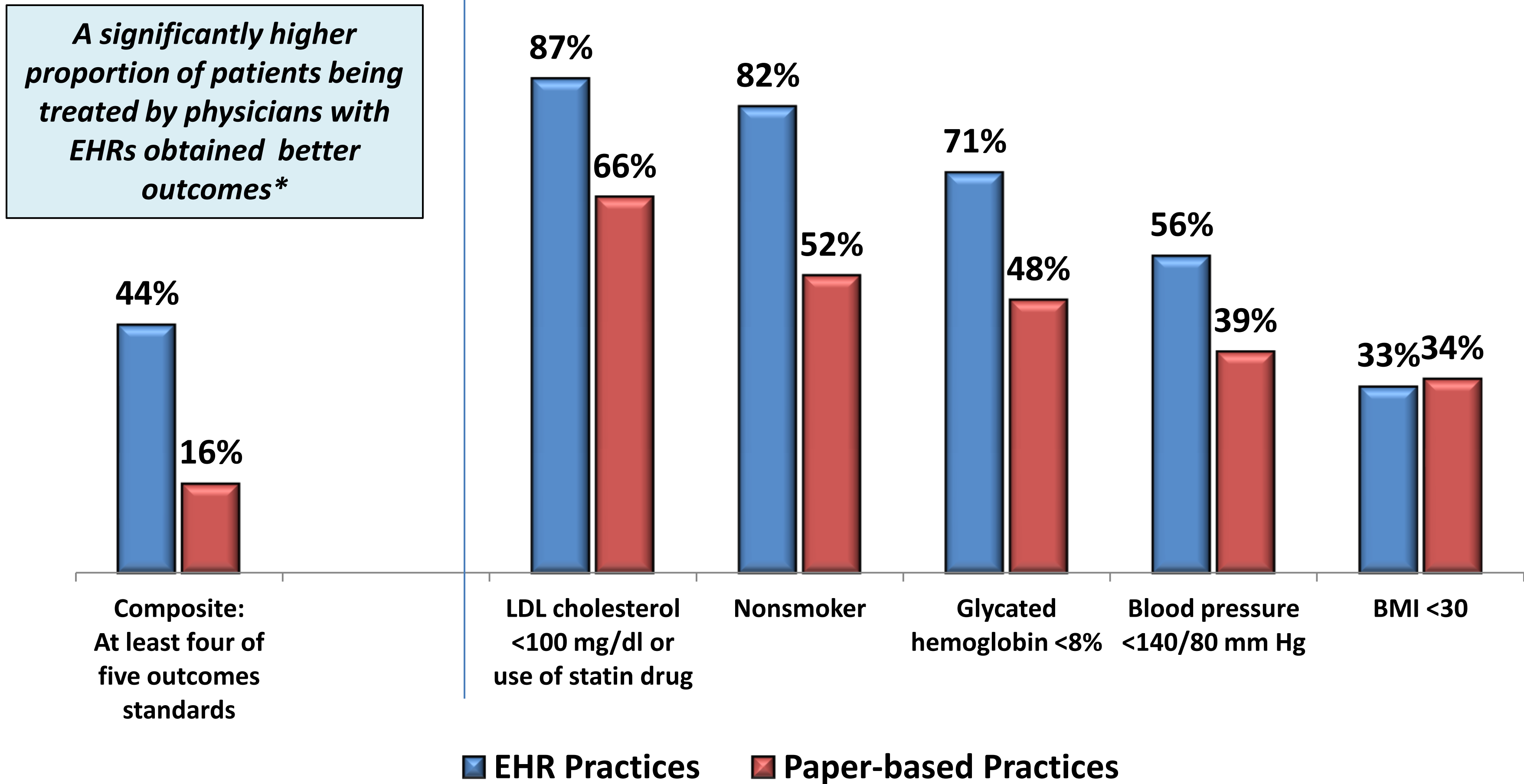
*A significantly higher proportion of patients being treated by physicians with EHRs received care that aligns with accepted treatment standards **



Source: Cebul, Randall D., et al. *New England Journal of Medicine*, August 2011

* Even after adjusting for patient demographic characteristics and insurance type, differences remain significant; $p<0.001$

Health Outcomes for Diabetes Patients: Patients treated by Physicians using EHR vs. Paper Medical Records



Source: Cebul, Randall D., et al. *New England Journal of Medicine*, August 2011

* Even after adjusting for patient demographic characteristics and insurance type, differences remain significant; $p<0.005$

What Have We Learned So Far?

1. Purposeful, aligned, widely embraced goals
2. Processes, people, information systems
3. Fitting of delivery interventions to patients
4. Continuous improvement (and yet…process fidelity)
5. Plan for deployment, including improvement skill deficits
6. Using data smartly amid the barrage
7. Awareness of magical thinking re: cost containment

The Medicare Shared Savings Program

Centers for Medicare & Medicaid Services

David Sayen, Regional Administrator

September 6, 2011

Care Continuum Alliance, San Francisco

Overview

- CMS's vision of its ACO program
- Summary of proposed rule
  - Eligible participants
  - Payment tracks
  - Assignment of beneficiaries
  - Quality framework
  - Beneficiary notification

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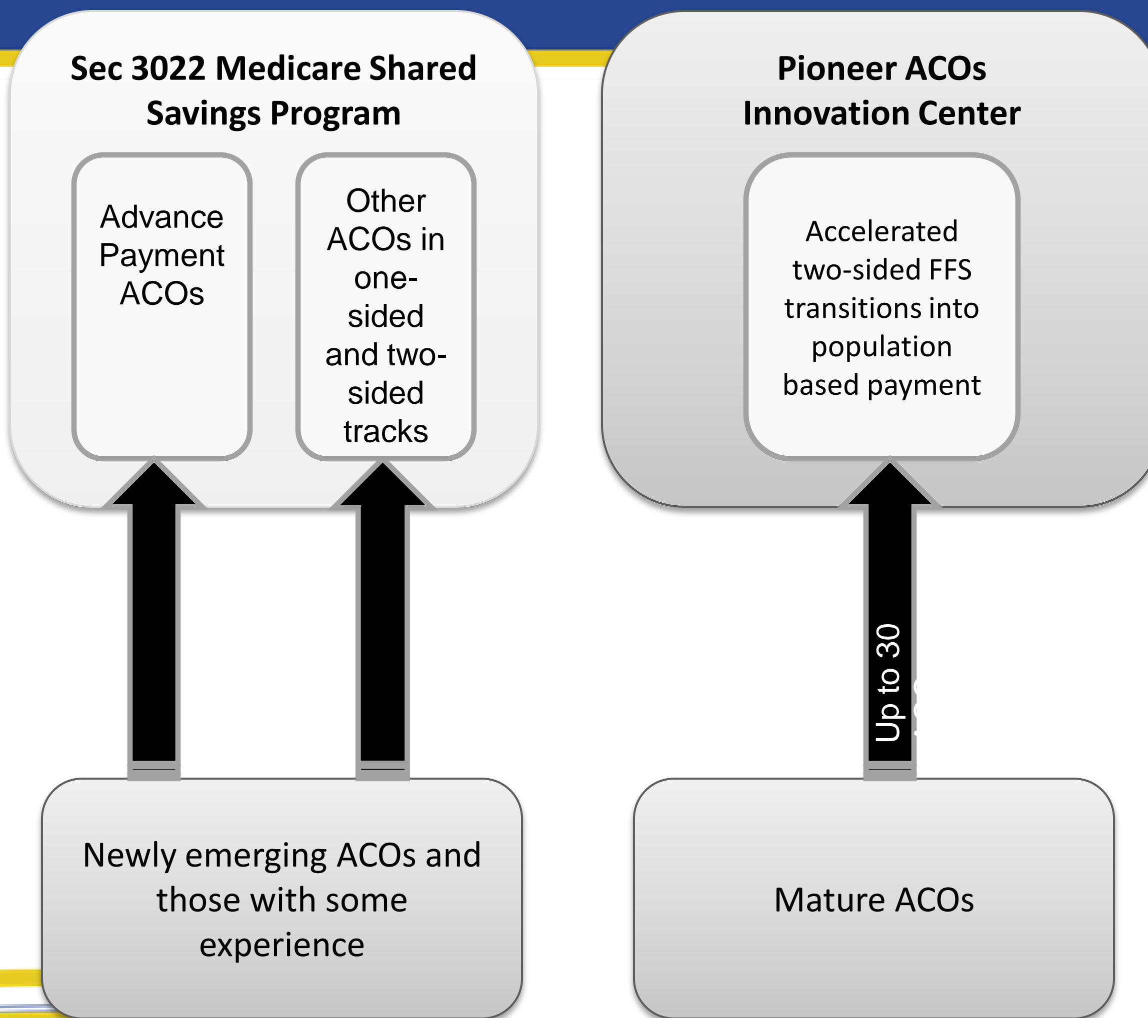
CMS's ACO Strategy: Creating Multiple Pathways for ACOs to Participate Based Upon ACO Readiness



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Background on the Medicare Sharing Savings Program

- Program authorized under section 3022 of the Affordable Care Act as part of Medicare traditional fee-for-service program
- Establishes a Shared Savings Program using Accountable Care Organizations (ACOs)
- ACOs are eligible to receive shared savings
- Program is to be established by January 1, 2012
- CMS and partner agencies conducted extensive outreach prior to issuing the rule
- CMS issued the notice of proposed rulemaking on March 31st 2011
- Comment period closed June 6, 2011

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Proposed Definition of an ACO

- A legal entity recognized and authorized under state law.
- Comprised of groups of health care providers and suppliers that:
  - Work together to coordinate beneficiary care
  - Invest in infrastructure and redesigned, coordinated care processes
  - Agree to be held accountable for quality, cost, and overall care of fee-for-service beneficiaries assigned to them
  - Establish a mechanism for shared governance

Proposed Eligible Organizations

- Physicians and professionals in group practice arrangements
- Networks of individual practices of physicians and other professionals
- Joint ventures/partnerships of hospitals and physicians and professionals
- Hospitals employing physicians and professionals
- Critical Access Hospitals (CAHs) that bill under Method II
- Other providers/suppliers may participate in an ACO but would not be used to directly assign patients

Proposed Two-Track Payment Approach

- ACOs may choose to participate in one of two tracks:
  1. An initial three-year agreement comprised of 2 years of one-sided shared savings and automatic transition to two-sided shared savings/losses in the final year
  2. A three year-agreement of two-sided shared savings/losses
- All ACOs who elect to continue in the program after the first agreement period must continue in the two-sided model
- Provides an "on-ramp" for organizations to gain population management experience and transition to risk arrangements

Assignment of Patient Population

- ACO accepts responsibility for an “assigned” Medicare patient population
- Assigned patient population is the basis for establishing and updating the financial benchmark, quality measurement and performance, and focus of the ACO’s efforts to improve care and reduce costs
- Patients assigned to ACOs based on the ***plurality*** of allowed charges for primary care services from primary care physicians (internal medicine, general practice, family practice, and geriatric medicine)
- Assignment will not affect beneficiaries’ Medicare benefits or choice of physician or any other provider
- CMS has proposed to ***retrospectively*** assign beneficiaries to an ACO

Proposed Quality Measurement & Performance

- 65 Quality measures separated into five domains:
    1. Patient/Caregiver Experience
    2. Care Coordination
    3. Patient Safety
    4. Preventative Health
    5. At-Risk Population/Frail Elderly Health
- ACOs that score higher will be eligible fore greater savings
- Measures aligned with current CMS measurement efforts

Proposed Beneficiary Notification Requirements

- ACO professionals must notify their patients that he/she is participating in the program (ACO)
- Beneficiary will receive general notification about the program and what it means for his/her care
  - Information will make clear that beneficiary continues to have freedom of provider choice
- Beneficiary will be informed his/her data may be shared with the ACO and be given the opportunity to decline to have data shared

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