Accountable Care Organizations

Impact on Health Care Disparities

Ronald Dunlap MD, FACC
Accountable Care Organization

• **Providers adopt financial accountability** for the health care needs of a population

• **Manage care of that population** across the health care continuum

• **Coordinate care among providers** using HIT, & process-level mechanisms to achieve improved quality and outcomes while reducing health care costs
ACO MODELS

• **Shared Savings**  ACO rewarded for spending below projected costs. Earning a percentage of the savings. Upside only

• **Risk Sharing**  Shared Rewards but also at risk with penalties for spending above projected costs. Upside and Downside Risk limited

• **Capitation Model**  ACO bears full Upside and Downside risk for spending above or below a negotiated capitation rate
How to Drive Accountable Care

Clinical Innovation
- EHR & Medication Management
- Meaningful Use
- Clinical Decision Support

Care Coordination
- Information Exchange
- Primary Care Integration
- Population & Community Health Management

Business Efficiencies
- Hosting & SaaS
- Revenue Cycle Management
- Managed Services
- Technology Partners

Delivering Accountable Care

Improve Outcomes

Reduce Cost
ACO LANDSCAPE

• Government sponsored ACOs
  • Medicare Shared Savings, Pioneer ACO

• Commercial Insurance Sponsored Organizations

• Medicaid ACOs  State sponsored

• Size ranges from small provider groups to large multi-state, well capitalized, integrated health systems with control over much of the care spectrum (Vertical Integration)
Accountable Care Design

Economic Flow of Funds

Payors
- Premiums
- Claims Expense (FFS)
- Case Mgmt Service Fee
- Shared Claims Savings

Accountable Care Organization
- Start up and ongoing Capital
- Periodic Dividend
- Provider Practice Investments
- Shared Claims Savings

Owners
- Provider Practice Investments
- Start up and ongoing Capital
- Periodic Dividend

Providers
- Primary
- Specialty
- Acute

ACO Enrollees
- Co-Pays, Deductible
Percent of ACOs by Provider Type

- Both Hospital and Physician Led 35%
- Physician Group Led 37%
- Hospital Led 28%

Source: Leavitt Partners 2015
ACO Types

- Independent Physician Group
- Physician Group Alliance
- Expanded Physician Group
- Independent Hospital
- Hospital Alliance
- Full Spectrum Integrated System
Current status of Gov’t ACOs

• **MSSP** started in 2012 and is up to 404 participating ACOs as of January 2015

• **32 Pioneers** have been reduced to 19 as a result of dissatisfaction with program requirements and/or poor results. Higher levels of risk sharing

• **Shared Savings** in both
Medicaid ACOs

- implemented state by state and vary in structure and payments. Likely to increase with the Medicaid expansion

- Challenged by:
  - Poor physician re-imbursement resulting in poor provider access
  - Minority beneficiaries with lower income and educational levels
  - Social determinants of health care
  - Higher risk populations concentrated geographically using underfunded “Safety Net Hospitals”
Medicaid ACO Hurdles

- **Risk adjustments** Spending targets adjusted for the mix of clinically vulnerable patients
- **Rewards for incremental improvement** in low performing ACOs rather than absolute targets
- **Performance measures** linked to patients with providers monitored across subgroups
- **Monitor for “patient dumping”** or avoidance
Incentives for Medicaid ACOs

- **Flexible design** based on patient population demographics and data
- **Advanced Payment** Model
- **Timely Evaluation** and adjustments for underperforming systems
- **Health IT** assistance
- **Improved Integration** given fragmented systems
- **Demonstration Projects** or clinical trials prior to ACO start up
Commercial ACOs

Rate of growth is increasing

- Have no restraints and are free to establish their own financial requirements, quality metrics and reporting timelines.

- Higher income populations avoiding some of the risks of government programs
Quality and Financial Results

• 877 million in savings as of Nov. 2014
• 460 million returned to ACOs
• Savings results are inconsistent among ACOs
• Only 22% of the MSSP qualified for SS payments in year one of the program
• Majority shared losses or broke even
• Quality improved overall. Pioneers improved 28 measures, MSSP improved on 30 measures

Leavitt Partners 2015
ACOs & Health Care Disparities

- **Racial disparities** linked to different sites of care
- **Site specific variation** in levels of institutional resources
- **Lower quality of care** in hospitals treating black and Latino patients
- **ACOs may reinforce racial/ethnic differences** in sites of care, exacerbating disparities

Pollack, Armstrong. JAMA 2011 April 27
Financial Stratification of ACOs

• **Profitable practices** are the most desirable partners
• **Wealthier hospitals** can consolidate profitable practices
• **Profitability** correlates with caring for fewer low income patients, disproportionately non-white
• **Financial factors** concentrate wealthy and racial/ethnic groups within different ACO’s
Effects of Financial Segregation

- **Inequities** in the quality and amount of resources of the ACO
- **Financial challenges** in systems caring for lower income patient impede the systems ability to:
  - Meet quality benchmarks
  - Implement cost saving programs
  - Qualify for shared savings
Leveling the Playing Field

- **Risk adjust** for patient characteristics in determining benchmarks
- **Monitor for avoidance** of at-risk patients
- **Mandate quality indicators** by race/ethnicity within the ACO
- **Examine the distribution of patients** by race/ethnicity between ACOs when assessing quality of care
- **Examine the Health Care Orgs** who opt out of ACOs
Quality of Care & Racial Disparities in Large Potential ACOs

- **Larger Groups** beneficiaries more likely to be white with lower poverty rates and higher education
- **Smaller disparities** in ordering LDL cholesterol testing and retinal exams
- **White beneficiaries** had lower rates of hospitalization for ACSCs related to cardiovascular disease and diabetes
- **Larger groups better quality performance** was not consistently associated with smaller racial disparities

Overall Comparison of Disparities Independent of Group Size

• Black beneficiaries with diabetes were less likely to have LDL cholesterol levels and retinal exams
• Black beneficiaries with cardiovascular disease were less likely to have LDL cholesterol levels and more likely to be hospitalized for ACSCs
• Large Groups had higher quality metrics (5 of 6) but racial disparities persisted.
Disparities by Group Size

Racial differences were smaller for large groups in LDL cholesterol testing and retinal exams.

Medium sized and Large groups performed better on all process measures for both black and white patients.

Racial differences in hospitalization for ACSCs were greater for black patients regardless of group size.
High Deductible Health Plans

- Rapidly increasing as employers seek to reduce their health care expense
- Reduce health care utilization & spending
- Health Savings accounts impact utilization
- Shift cost from employers to employees
- Enrollees spent less on drugs and in/out patient care but more on Emergency Room visits
- Increase the need for transparency in costs
Unintended Results of HDHP

• Preventive care is avoided by a greater number of patients despite adequate coverage
• Delayed or postponed care with potential increases in the severity of disease
• Lower income and less educated patients avoid preventive care & screenings to a greater degree
• Complexity of the plans requires better education regarding benefits and costs.
• Increased “bad debt” for Hospitals and providers due to uncollectable deductibles
Narrow Health Care Networks

• Aim to lower cost by aligning physicians, patients, and facilities
• Restrict access to only those facilities and physicians
• Give the network leverage with providers
• Aim to steer care to high value (low cost - high quality providers)
• Higher costs to patients for “going out of network”
• Straightforward to implement
Disadvantages of Narrow Networks

• May restrict patient’s access to important providers
• Network Adequacy  May not have an adequate number of providers of necessary services
• Services may not be geographically accessible
• Sicker patients may be discouraged from enrolling
• Services may be driven more by cost than quality, lowering value
• Lack of consumer education on high value providers makes patient choice of network difficult