We Need to Make the ACO Idea Successful

A Perspective from Kaiser Permanente

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Where Do We Go from Here? The Future of Health Reform
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Agenda

- Context
- Reflections from our experience about certain ACO design elements
- One final thought
The ACO concept is a broader idea than just what is contained within the Medicare Shared Savings Program draft regulations.

It should lead eventually to the creation of functionally integrated delivery systems, capable of receiving prospective payment, and being accountable for the quality and cost of care of a population.
Exhibit ES-1. Organization and Payment Methods

Less Feasible

More Feasible

Continuum of Payment Bundling

Fee-for-Service

Medical Home Payments

Global Case Rates

Full Population Prepayment

Outcome measures; large % of total payment

Care coordination and intermediate outcome measures; moderate % of total payment

Simple process and structure measures; small % of total payment

Small practices; unrelated hospitals

Independent Practice Associations; Physician Hospital Organizations

Fully integrated delivery system

Continuum of Organization

Source: The Commonwealth Fund, 2008
Context, con’t

- The Shared Savings Program model may or may not gain traction; there is market resistance pending the final regulations; CMS flexibility issues due to statutory constraints?; OMB resistance?

- The work of CMMI will be vital; the “Pioneer ACO Model” is a start
The Pioneer ACO Model

- Option for prospective attribution (alignment)
- ”Affirmative attestation” for beneficiaries
- Requires multi-payer arrangements for “outcome-based payments”
- Potential for coordination with Part D plans
Context, con’t

- The Shared Savings Program model may or may not gain traction; there is market resistance; flexibility issues due to statute and scoring; possible CMS implementation issues.

- The work of CMMI will be vital; the “Pioneer ACO Model” may be a start.

- ACO developments in the commercial market will also have a profound impact, for good or ill.
If population-based performance on quality and cost is the goal of ACOs, it will eventually require that there is a fully “aligned” population.

Is there a space between MA and the Shared Savings Program attribution model? Is it possible to get off the Parts A+B “chassis”? 

Choice of ACO; the same as HMO?
Payment Incentives

- It is easier to envision workable payment incentives for physicians than for hospitals.
- KP hospitals are cost centers, not revenue centers.
- Not all hospitals have “excess” patients.
Partial Capitation

- What does it mean?
- ACO “risk” assumption has two basic dimensions
A Schematic of ACO Risk Assumption

“Depth” of Risk

- Full Risk Capitation
- Corridor Capitation
- FFS +/- “Bonus”
- FFS Only

“Breadth” of Risk

- Primary Care
- Specialty Care
- Hospital Costs
- Referral Costs
- Non Referral Costs
- Admin. Rx (B)
- Prescription Rx (D)
“Partial” Capitation

- What does it mean?
- ACO “risk” assumption has two basic dimensions
- In capitation, variants of both “breadth” and “depth” can be shared with the payer; this should evolve over time, by direction
- Flexibility in design and gradualism in implementation will be important
It is Good to Have a Payer “Partner”

- The value of shared incentives
- The value of a long term horizon for investments in care delivery improvement
- The ability to coordinate benefit design with delivery system capabilities
- Can CMS do this?
Physician Leadership

- ACOs won’t work without committed physicians
- Physicians as leaders (and followers) and managers
- The physician (and hospital) governance model is key
- The Shared Saving Program draft rule has this right
If the ACO idea fails ............
what comes next?