

# Social Work and Accountable Care Organizations

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# Factors That Distinguish High-Performing Accountable Care Organizations in the Medicare Shared Savings Program\*

- Background: Value-based purchasing and Accountable Care Organizations (ACOs)
- Current study: inductive, mixed-methods
- Results from quantitative and qualitative data
- Discussion

\*D'Aunno, Broffman, Sparer, Kumar, *Health Services Research*. DOI: 10.1111/1475-6773.12642



# Value-Based Purchasing (VBP)

- **Broad set of payment strategies that link financial incentives to providers' performance on defined set of measures**
- **Both public, private payers involved (e.g., Blue Cross)**
- **10-year old movement, started by Centers for Medicare and Medicaid Services (CMS)**
- **ACA mandates CMS to continue to innovate on VBP**





# Volume (Current Model) to Value-Based Purchasing



## Volume focus

- Payment systems based on fee-for-service; limited financial risk
- Providers have incentives to increase payment rates, specialization/intensity, and volume; fragmentation of providers (“silos”)
- Limited focus on outcomes and information sharing



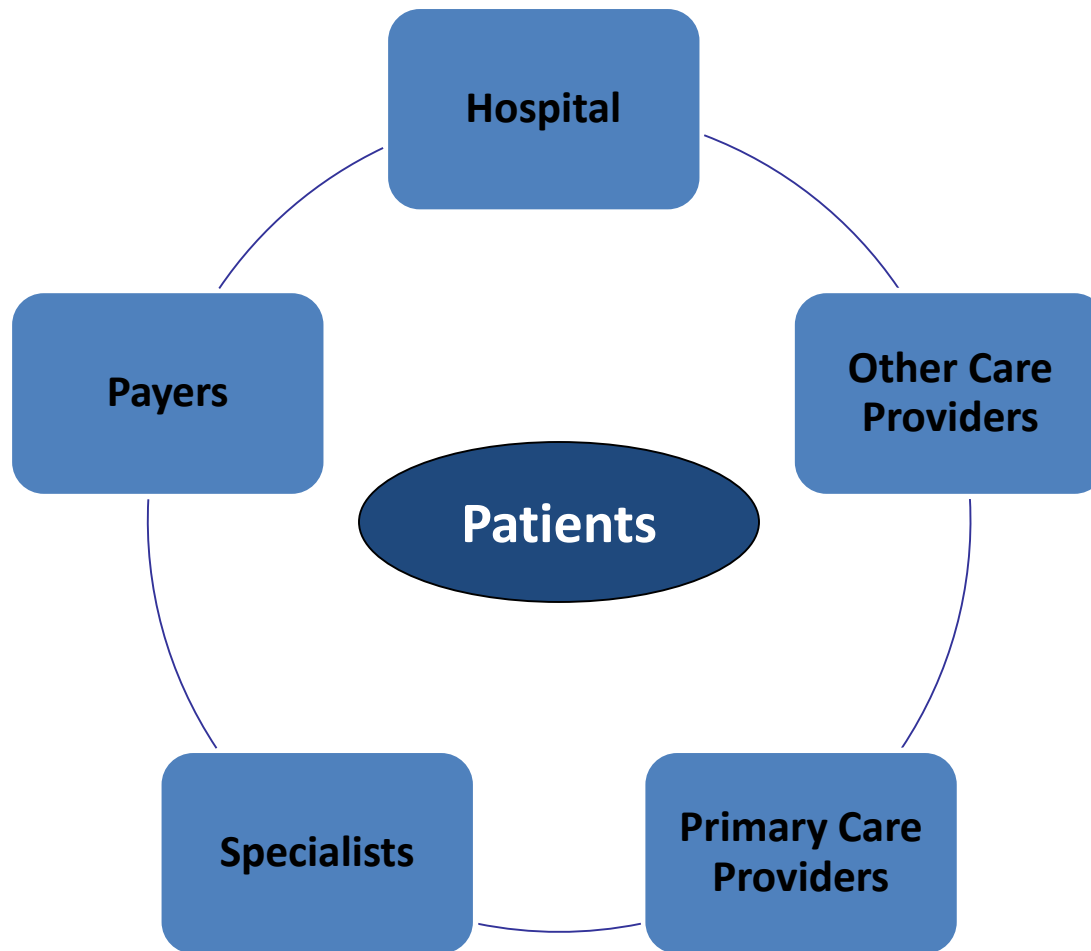
## Value focus



- Focus on maximizing value (lower cost and higher quality) of health care delivered by aligning incentives and managing risk
- Care coordination driven by standardized protocols, use of technology for information sharing
- Investment for clinical integration, population health, and other cost reduction/revenue enhancement opportunities to respond to new payment systems



# VBP Envisions Integrated Care



# Accountable Care Organizations

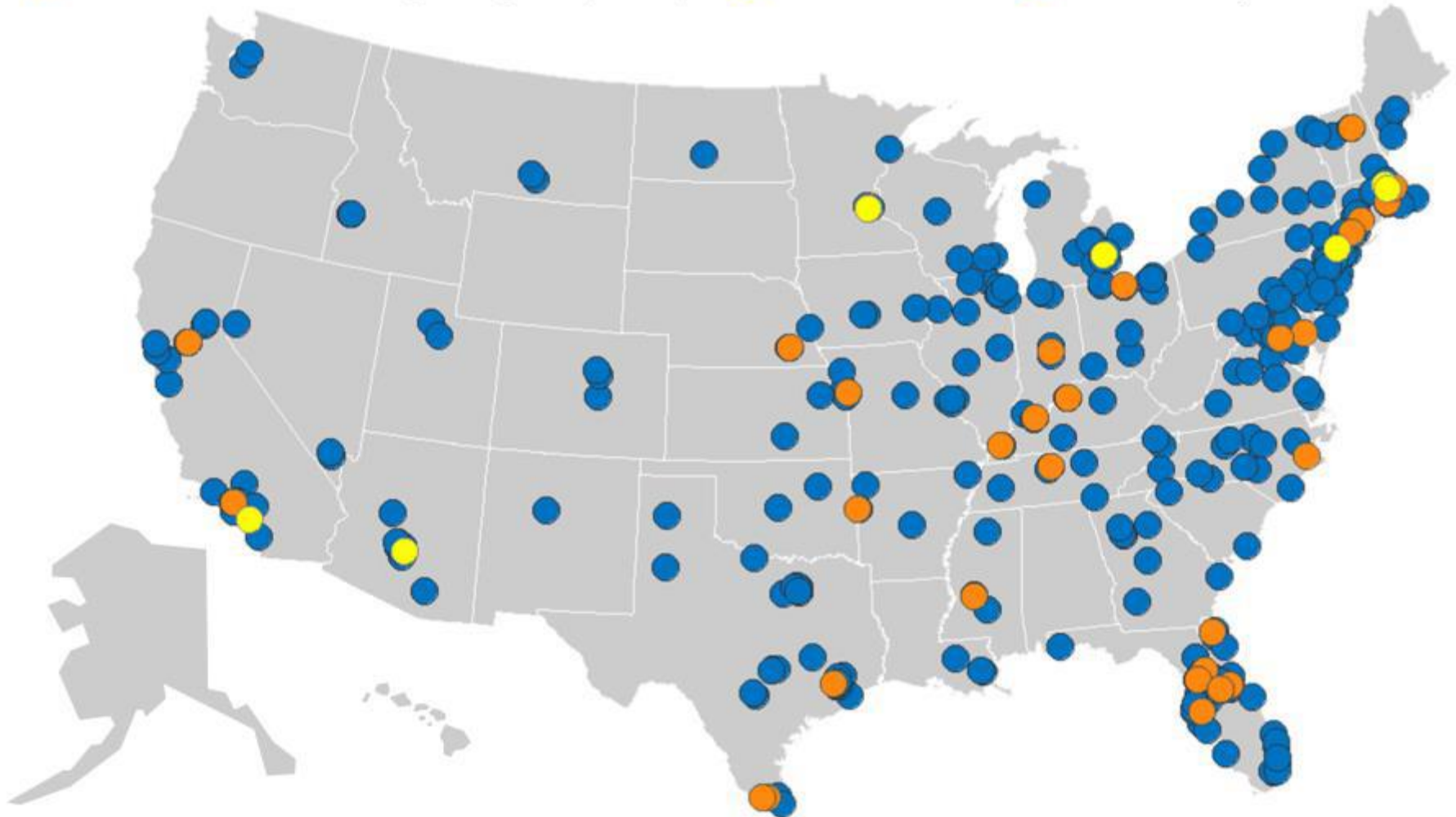
- **Organization of health care providers that agrees to be accountable for quality, cost and overall care of an assigned population of individuals**
- **ACOs increasingly take on financial risk**
  - **if meet standards for quality, are eligible to receive share of savings**
  - **if actual per capita expenditures for assigned individuals (often Medicare beneficiaries) are sufficiently below specified benchmark amount**



Figure 2

## Accountable Care Organization (ACO) Models

● Medicare Shared Savings Program (MSSP) ● Pioneer ACOs ● Advance Payments ACOs



NOTE: One MSSP in Puerto Rico not pictured.

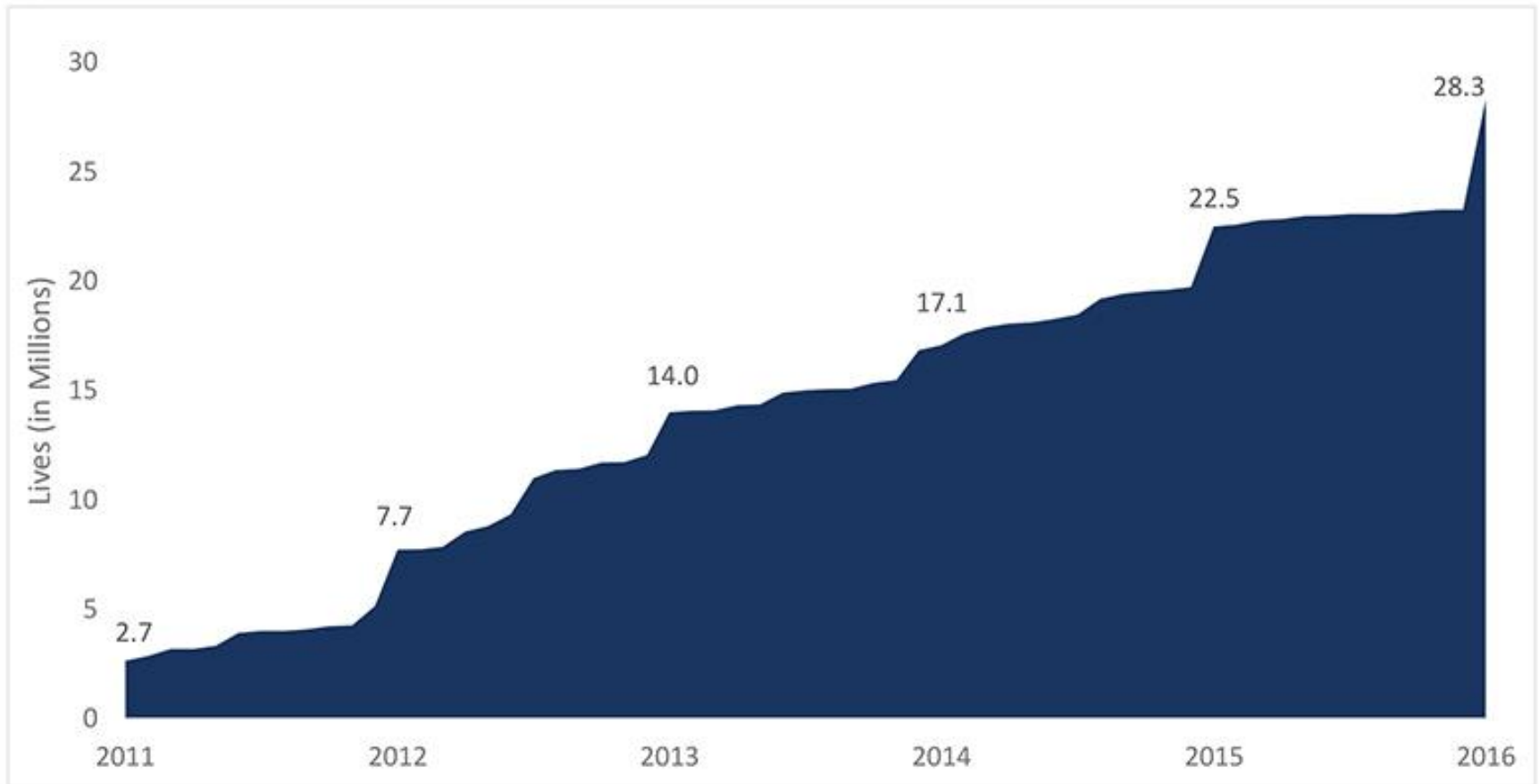
SOURCE: Map data downloaded January 19, 2016 from CMS: <https://innovation.cms.gov/initiatives/map/index.html>. Participant counts in this dataset are updated periodically. See Table 4 for official counts in most recently-available CMS documents and webpages.

# Number of ACOs, 2011-2016





# Number of Individuals Enrolled in ACOs, 2011-2016



# How Well Are ACOs Performing?

- Research shows mixed results for ACO performance
- MSSP ACOs formed in 2012 and 2013 show small, but meaningful, reductions in spending
- Unchanged or improved quality of care, but only for ACOs that entered the program in 2012 (McWilliams et al., 2016)
- 333 MSSP ACOs (2014)
  - improved on 30 of 33 quality measures compared to 2013
  - but, only 28% achieved targets for cost control, thereby achieving a shared savings payment
  - number of MSPPS ACOs that received shared savings bonuses increased slightly to 30% in 2015 (Muchmore, 2016)



# Research Context and Question

- **Universal American (UA) Insurance partners with physician groups in 36 geographic locations to form Medicare Shared Savings ACOs (in 2012)**
- **UA had good experience with the Medicare Advantage (MA) managed care program**
- **ACOs viewed as a strategic opportunity**
- ***What factors distinguish high-performing from low-performing ACOs ?***



# Study Design: Mixed Methods

- **Phase 1: analyzed CMS claims data on local ACO performance**
  - measured performance in year prior to entry into ACO and first year of ACO performance (i.e., data on cost, quality)
- **Phase 2: intensive site visits to 6 ACOs: 3 high-performers, 3 low performers**
- **Site visit objective: identify key factors that differentiate high vs. lower-performing ACOs**



# Phase 1: Measures of Cost and Quality

- **Utilization (cost) measures:**
  - Avoidable inpatient admission rates
  - Rates of readmission to an inpatient facility within 30 days of discharge
  - Emergency Department visit rates
- **Quality measures from Healthcare Effectiveness Data and Information Set (HEDIS):**
  - Diabetes
  - Congestive heart failure
  - Chronic obstructive pulmonary disease





# Phase 1 Measures (2)

- **Overall performance score: the average utilization (cost) rank and average quality rank were calculated for each ACO**
  - **for both the first program year and 1-year change from baseline**



# Phase 1 Results: Characteristics of High and Low Performers

- **Both the low and high-performing ACOs had similar patterns of chronic disease and CMS risk scores (HCC - level of severity)**
- **High performing ACOs had more members**



# Phase 1 Results: Characteristics of High and Low Performers (2)

- **All high-performing ACOs had rates of avoidable costs that were below the average**
- **All high-performing ACOs improved performance on all study measures between the baseline and first year**



## Phase 1 Results (3)

- **All low-performing ACOs had higher, above-average costs on all measures**
- **All low-performing ACOs had decreased performance on all measures between the baseline and first year**



# ACO Characteristics and Performance Rankings

ACO Label	Geographic Region	Total Members	Percent of Members with Chronic Disease	Average HCC Score	Final Rank
A*	Middle Atlantic	12,083	65.1%	0.98	1
B	New England	5,984	54.7%	0.85	2
C	South Atlantic	8,633	58.7%	0.92	3
D*	Middle Atlantic	12,745	54.2%	1.01	4
E	South Atlantic	8,441	41.4%	0.98	5
F	New England	8,173	53.1%	1.02	6
G*	West South Central	27,336	25.0%	1.06	7
H	South Atlantic	5,182	59.8%	1.05	8
I	East North Central	9,298	62.2%	1.36	9
J	South Atlantic	17,648	46.1%	0.87	10
K	South Atlantic	7,966	70.2%	1.02	11
L*	South Atlantic	11,290	56.7%	0.97	12
M*	South Atlantic	8,667	57.7%	1.04	13
N*	West South Central	7,049	71.0%	0.99	14
O	New England	5,485	59.8%	1.00	15
P	East South Central	5,518	60.5%	1.03	16





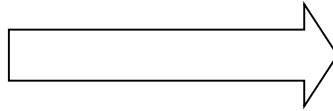
# Phase 2: Preliminary Model of ACO Performance

## Market and Community Context

- Mix of health plans, payers and health care/social service providers
- Collaboration/competition among health care/social service providers
- Socioeconomic, demographic characteristics of community

## ACO Governance, Management, Operations

- Information systems
- Care management models
- Financial incentives; payment arrangements
- Management and leadership
- Governance
- Effective relationships with UA and consumers



## ACO Performance

- CMS quality standards
- Patient and physician satisfaction
- Service use (primary care; emergency room visits; hospitalizations; re-hospitalizations)
- CMS per capita expenditures; cost of care (cost avoidance, e.g., reduced hospitalizations)

# Data Collection and Analysis

- **Semi-structured interviews, based on model; average of 10 individuals per site**
- **Initial codes serve as an organizing framework for the data (based on preliminary model)**
- **Research team members debriefed after each interview to review content, highlight key information**
- **Following each site visit, team members distributed individual notes that they took during each interview**
  - **notes combined and used to guide regular, ongoing analytic meetings in which insights from each site were synthesized and compared to prior site data**
- **Identified recurrent concepts, both within and across sites, that prior literature did not capture; we incorporated these concepts into the coding structure**



## Data Collection and Analysis (2)

- We used data collection and analysis approaches to limit bias
  - recording and verbatim transcription of interviews
  - use of Atlas software in data analyses
  - reliability checks among the two research team members from each site visit
  - corroboration of interview data with records data
  - use of multiple key respondents at each site



## Type and Number of Respondents by ACO Site

	<b>Central (UA) Leaders</b>	<b>Physician Leaders</b>	<b>Care Delivery Staff</b>	<b>Managers</b>
<b>Site A</b>	<b>1</b>	<b>1</b>	<b>4</b>	<b>4</b>
<b>Site D</b>	<b>1</b>	<b>1</b>	<b>1</b>	<b>1</b>
<b>Site G</b>	<b>2</b>	<b>1</b>	<b>3</b>	<b>1</b>
<b>Site L</b>	<b>2</b>	<b>1</b>	<b>2</b>	<b>2</b>
<b>Site M</b>	<b>1</b>	<b>1</b>	<b>2</b>	<b>4</b>
<b>Site N</b>	<b>1</b>	<b>1</b>	<b>5</b>	<b>3</b>



# Results from Site Visits: Factors Differentiating High- from Low-Performers

- Relatively large, well-established physician groups (over 200 physicians) that provided cost-effective care prior to ACO formation
- Effective, long-serving physician leaders
  - focused on building a high-performing physician group





## Differentiating Factors (2)

- Effective feedback to physicians
  - independent of CMS data
- Relatively extensive, sophisticated use of electronic medical records
  - within the group
  - combined with use of regional health information systems



## Differentiating Factors (3)

- Collaborative relationships with local hospitals
  - enabled timely and consistent access to patient information
- Embedding care coordinators in physician practices



# **Additional Key Themes: The Role of Social Services**

- **Care coordinators may be generally ill-equipped to deal with the “non-medical” social support needs of beneficiaries; most care coordinators are nurses**
  - **well-qualified to assist with classic medical needs**
  - **less able to help beneficiaries with barriers such as being without the funds to pay for medications or transportation to physicians’ offices**
  - **nurse coordinators described efforts to procure hearing aids and wheelchair ramps, tasks outside of their typical training and expertise**



## Additional Key Themes (2)

- **in response, some sites have hired social workers as part of the care coordination team**
- **but these hires are the exception**
- **little evidence on whether and how they are making a difference**



## **Additional Key Themes (3)**

- **Weaknesses in CMS policy and performance**
  - **Lack of timely data**
  - **Weak financial incentives**
  - **Defining membership in an ACO (“attribution”)**
- **The logics (“mental models”) of founders matter**
  - **ACOs vs. managed care**



# Discussion

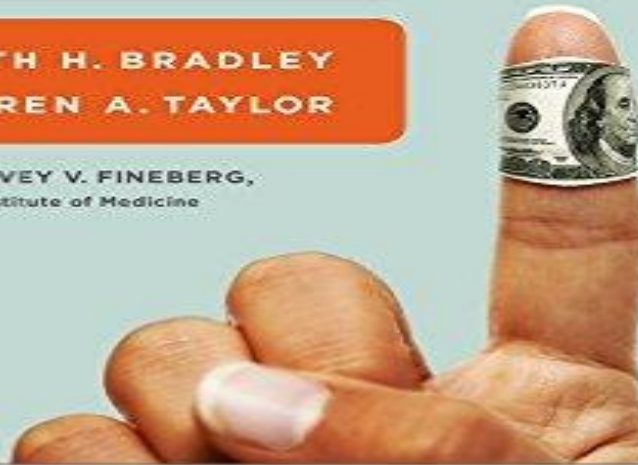
- **Limitations**
  - **Convenience sample, small number of site visits**
  - **Particular type of ACOs**
    - **Primary care-centered**

# THE AMERICAN HEALTH CARE PARADOX

.....  
WHY SPENDING MORE  
IS GETTING US LESS

ELIZABETH H. BRADLEY  
AND LAUREN A. TAYLOR

Foreword by HARVEY V. FINEBERG,  
President of the Institute of Medicine





**FOR IMMEDIATE RELEASE**

**January 5, 2016**

**Contact: HHS Press Office**

**202-690-6343**

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First-ever CMS Innovation  
Center pilot project to test  
improving patients' health by  
addressing their social needs

*\$157 million in funding will  
bridge clinical care with social  
services*



# Accountable Health Communities Model

- Based on emerging evidence that addressing health-related social needs through enhanced clinical-community linkages can improve health outcomes and reduce costs
- Unmet health-related social needs, such as food insecurity and inadequate or unstable housing...
  - may increase the risk of developing chronic conditions
  - reduce ability to manage these conditions
  - increase health care costs



# Accountable Health Communities Model (2)

- Over a five-year period, CMS will implement and test a three-track model based on promising service delivery approaches. Each track features interventions of varying intensity that link beneficiaries with community services:
- **Track 1 Awareness** – Increase beneficiary *awareness* of available community services through information dissemination and referral
- **Track 2 Assistance** – Provide community service navigation services to *assist* high-risk beneficiaries with accessing services
- **Track 3 Alignment** – Encourage partner *alignment* to ensure that community services are available and responsive to the needs of the beneficiaries



# Cost Containment and the Tale of Care Coordination

“We should coordinate care not to save money but because coordinated care is better care” --J. Michael McWilliams. MD., Ph.D.

*New England Journal of Medicine 375;23 [nejm.org](http://nejm.org) December 8, 2016*



# What Does the Future Hold?

- **Medicare Access and CHIP Reauthorization Act (MACRA)**
  - **Bipartisan support (2015)**
  - **Focuses on value based purchasing**

