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

<table>
<thead>
<tr>
<th>Volume focus</th>
<th>Value focus</th>
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<tbody>
<tr>
<td>- Payment systems based on fee-for-service; limited financial risk</td>
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<tr>
<td>- Providers have incentives to increase payment rates, specialization/intensity, and volume; fragmentation of providers (“silos”)</td>
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<td>- Limited focus on outcomes and information sharing</td>
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<tr>
<td>- Focus on maximizing value (lower cost and higher quality) of health care delivered by aligning incentives and managing risk</td>
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<td>- Care coordination driven by standardized protocols, use of technology for information sharing</td>
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<tr>
<td>- Investment for clinical integration, population health, and other cost reduction/revenue enhancement opportunities to respond to new payment systems</td>
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VBP Envisions Integrated Care

Hospital

Payers

Other Care Providers

Specialists

Primary Care Providers

Patients
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](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
Limitations (Pre-Emptive Surrender Slide)

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

<table>
<thead>
<tr>
<th>ACO Label</th>
<th>Geographic Region</th>
<th>Total Members</th>
<th>Percent of Members with Chronic Disease</th>
<th>Average HCC Score</th>
<th>Final Rank</th>
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</thead>
<tbody>
<tr>
<td>A*</td>
<td>Middle Atlantic</td>
<td>12,083</td>
<td>65.1%</td>
<td>0.98</td>
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<tr>
<td>B</td>
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<td>5,984</td>
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<td>C</td>
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<tr>
<td>K</td>
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<td>7,966</td>
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<tr>
<td>L*</td>
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<td>11,290</td>
<td>56.7%</td>
<td>0.97</td>
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<tr>
<td>M*</td>
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<td>1.04</td>
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<tr>
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<tr>
<td>O</td>
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<tr>
<td>P</td>
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<td>5,518</td>
<td>60.5%</td>
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</table>
**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
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
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 December 8, 2016*
What Does the Future Hold?

- Medicare Access and CHIP Reauthorization Act (MACRA)
  - Bipartisan support (2015)
  - Focuses on value based purchasing
THANK YOU!
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
## Type and Number of Respondents by ACO Site

<table>
<thead>
<tr>
<th>Site</th>
<th>Central (UA) Leaders</th>
<th>Physician Leaders</th>
<th>Care Delivery Staff</th>
<th>Managers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Site A</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Site D</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Site G</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Site L</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Site M</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>4</td>
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<tr>
<td>Site N</td>
<td>1</td>
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