

BROOKINGS

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# Health IT and Accountable Care

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# Bipartisan Health Care Reform

## Includes Reforming Health Care Delivery


- **Provider Payment Reform**
  - » Initial support for coordinated care (e.g., medical homes, community health teams)
  - » Initial payments for reporting/performance, bundling
  - » Transition to accountability for results
- **Coverage/Benefits Reform**
  - » More effective competition through insurance market and tax reform
  - » Value-based benefits
- **Better Information**
  - » Effective health IT
  - » Better evidence

# Key Elements of Effective Payment Reform

- Foster greater accountability for quality and cost
  - » Integrated reforms “build in” expectations of cost containment and quality improvement – not just reducing payment updates
- Feasible across diverse practice, organizational, and market settings
  - » Reforms should be flexible to allow for variation in the strategies that local health systems use to improve care
- Transition payments from rewarding volume and intensity to increasing value
  - » Payments should encourage collaboration and shared responsibility among providers and consistent incentives/measures from payers
- Help consumers make better decisions – and reward them for doing so
  - » Increased accountability on the part of providers should be accompanied by improved incentives and information for consumers

# Evolution of Payment Reform

From Incremental Reporting Bonuses to More Comprehensive and Integrated Population-Level Reforms



Supporting Better Performance		Paying for Better Performance		Paying for Higher Value	
<p><b>Pay for reporting.</b> Payment for reporting on specific measures of care. Data primarily claims-based.</p>	<p><b>Payment for coordination.</b> Case management fee based on practice capabilities to support preventive and chronic disease care (e.g., medical home, interoperable HIT capacity).</p>	<p><b>Pay for performance.</b> Provider fees tied to one or more objective measures of performance (e.g., guideline-based payment, nonpayment for preventable complications).</p>	<p><b>Episode-based payments.</b> Case payment for a particular procedure or condition(s) based on quality and cost.</p>	<p><b>Shared savings with quality improvement.</b> Providers share in savings due to better care coordination and disease management.</p>	<p><b>Partial or full capitation with quality improvement.</b> Systems of care assume responsibility for patients across providers and settings over time.</p>

# Accountable Care Organizations

- Accountable Care Organizations (ACOs) are multi-stakeholder public/private collaborations for which providers assume responsibility for overall patient care across providers and settings through:
  - » Voluntary provider participation, broad payer participation, local accountability, payment incentives, and performance measurement
- ACO configurations vary reflecting the diversity of local health care markets and preferences of participants; however, several characteristics are essential for all ACOs:

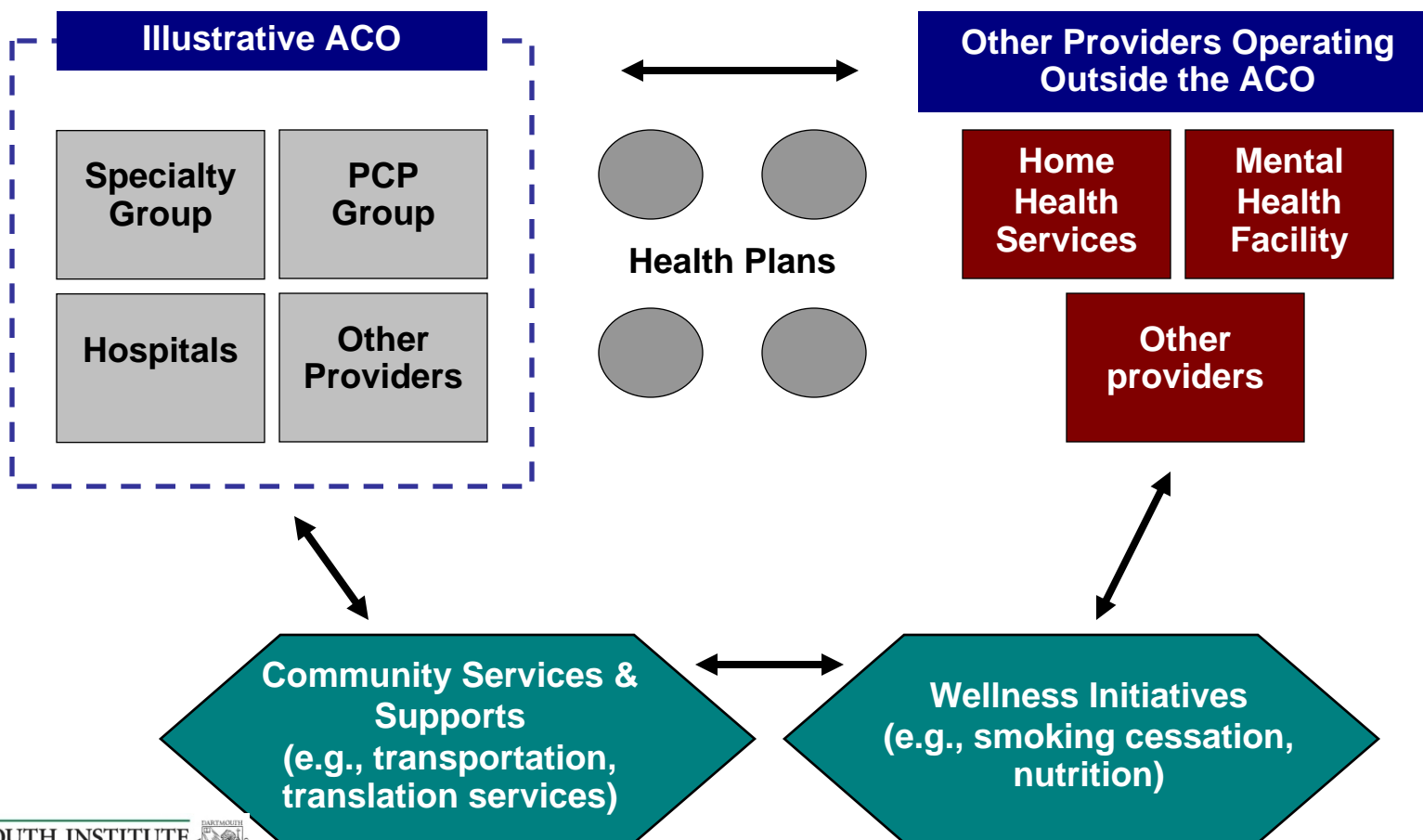
Can provide or manage a continuum of care as a real or virtually integrated delivery system

Are of sufficient size to support comprehensive performance measurement

Are capable of prospectively planning budgets and resource needs

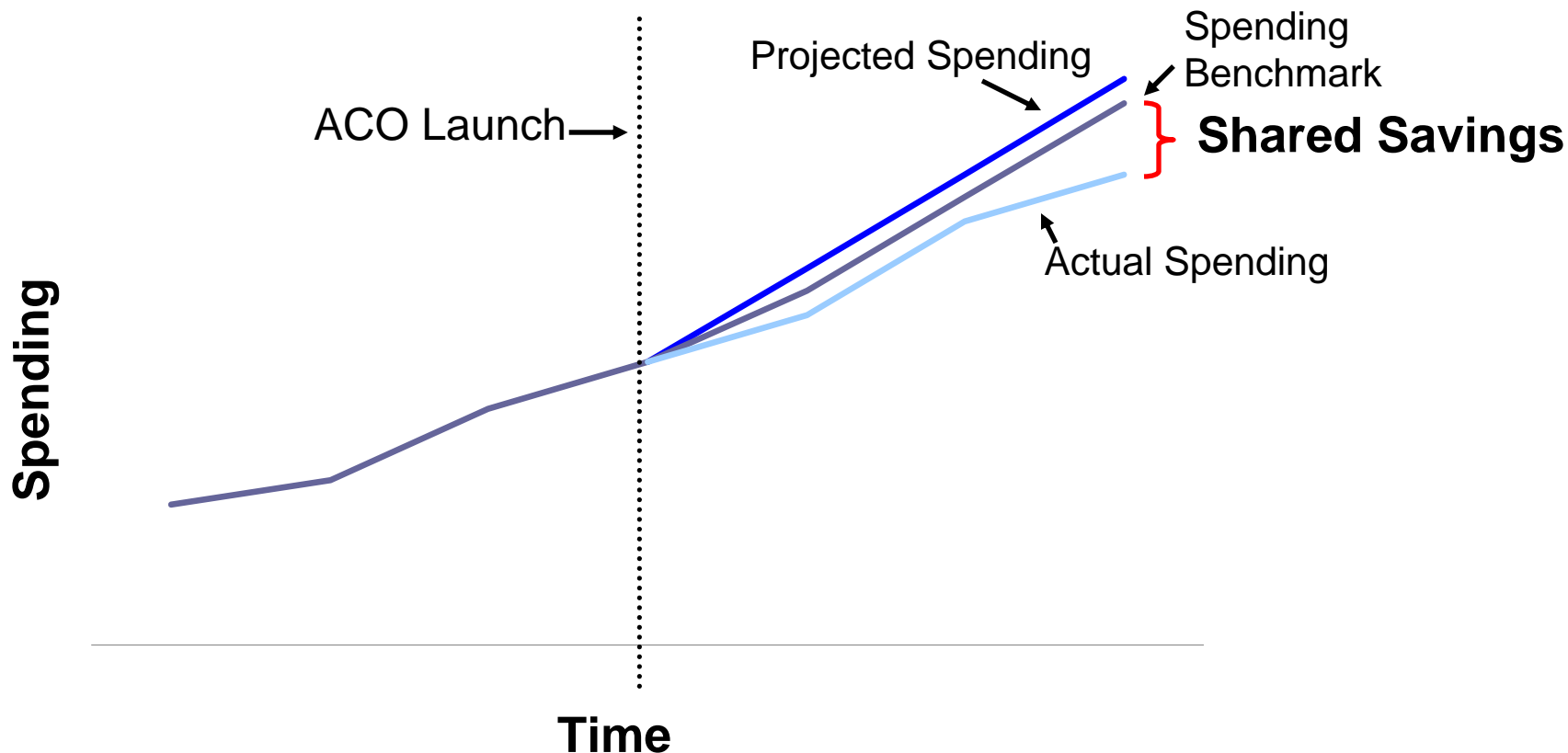
# Integrating Care through ACOs

ACOs can serve as “integrators” that link fragmented entities of the health care system around accountability for value.



# How Do “Shared Savings” Models Work?

Initial shared savings derived from spending below benchmarks



## Implementing Accountable Care, Step by Step

1. Local providers and multiple participating payers agree to pilot ACO reform
2. ACO develops list of participating providers and payers
3. Patients are “assigned” to ACOs (e.g., based on preponderance of E&M codes)
4. Actuarial projections about future spending are based on prior data
5. Determine/negotiate spending benchmark and shared savings
6. ACO implements capacity, process, and delivery system improvement strategies (e.g., reducing avoidable hospitalizations, coordinating care, using health IT effectively)
7. Progress reports on cost and quality are developed for ACO beneficiaries (e.g., condition-specific performance measures)
8. Periodically, total and per capita spending are measured for all patients (regardless of whether they received care from ACO providers)
9. Savings under the benchmark is shared between providers and payers
- 10. Adjustments in contracts (if needed), further investments and activities to improve care

# ACOs and Health Care Reform

- ACOs are designed to reflect key lessons from effective payment and delivery reforms:
  - » Supports providers when they take steps to improve care and lower costs
  - » Fosters greater accountability for quality and cost across diverse practice, organizational, and market settings.
  - » Promotes high-value care over high-intensity care
  - » Helps consumers make better health care decisions
- ACOs are fully compatible with other payment reforms, including:
  - » Bundled payments
  - » Care coordination payments
  - » Chronic disease management incentives
  - » Health IT adoption incentives...

# HIT Policy Committee, June 16, 2009

## Framing Statement

*“We recommend that the ultimate goal of meaningful use of an Electronic Health Record is to enable significant and measureable improvements in population health through a transformed health care delivery system. The ultimate vision is one in which all patients are fully engaged in their healthcare, providers have real-time access to all medication information and tools to help ensure quality and safety of the care provided while also affording improved access and elimination of health care disparities. This ‘north star’ must guide our key policy objectives, the advanced care processes needed to achieve them, and lastly, our specific use of information technology that will enable the desired outcomes, and our ability to monitor them.”*

## Example of Payment Reforms Fitting Together to Promote Accountable Care: Markle / Brookings/ CAP Framework

- **Patient-Centered, Meaningful Use of Health IT:**
- *Demonstrates that the provider makes use of, and the patient has access to, clinically relevant electronic information about the patient to **improve patient outcomes and health status, improve the delivery of care, and control the growth of costs.***
- **Initial Meaningful Use Requirements (2011-2012):**
- *Demonstrates that the provider makes use of, and the patient has access to, clinically relevant electronic information about the patient to **improve medication management and coordination of care***

## Implication: Tie HIT Payments Tightly to Quality Reporting and Results

- Many of the ONC-proposed metrics are very tightly tied to results
- But no demonstrable improvement goal in near term

### Further Steps

Show early and measurable progress toward meaningful use goals...

- Apply clear principle of paying for reporting and then results (“sufficient statistic” for HIT use to coordinate and then improve care), set concrete thresholds over time
- Focus payments on measures tightly linked to vision goals
- Validation occurs automatically as by-product of using systems
- Rapidly develop valid measures to fill gaps (e.g., medication errors, preventable hospitalization and readmission, duplicate testing and unnecessary imaging)

## Example of Integrating HIT Payments with Accountable Care

- 2011: feasible reporting on quality as “sufficient statistics” for meaningful use of health IT
  - » % of diabetics with HgbA1c performed/controlled (EMR maintains patient registry, links to lab reporting)
  - » 30-day readmission rates (EMR data linked to discharge data)
  - » Childhood immunization rates
  - » HIPAA compliance
  - » Electronic PQRI reporting
- Later: increasing range of performance measures, payments tied to performance not just reporting (many examples in HIT Policy Committee report)

# Reforms Should Reinforce Public/Private, Multi-Stakeholder Collaboration

- Public/private, multi-stakeholder reform processes can provide greater momentum and support
  - » Common quality measures and reporting requirements across payers
  - » Integrated performance information from a variety of data sources means more accurate and complete performance measurement
  - » Payment reforms, including support for health IT, and benefit reforms based on these measures can reinforce each other
- Does not require changes in antitrust laws – and better evidence on quality and efficiency can promote more effective antitrust enforcement

# New Medicare “Shared Savings” Demos Reflect Multi-Stakeholder Approaches

Features	Demo 1	Demo 2
<b>Key stakeholders</b>	Commercial payers, self-funded employers, Medicaid MCOs, and Medicare, range of providers	Commercial payer, public employees, Medicaid, and Medicare, range of providers
<b>Baseline Data</b>	Dynamic baseline computed using previous trends and comparison group trends for each cohort of providers	Expected costs calculated annually based on risk adjusted data from control groups
<b>Controls</b>	Control areas in neighboring metropolitan areas	Control areas are in-state counties
<b>Savings Threshold</b>	Demo receives 80% of savings above threshold compared to control group	Demo receives 80% of savings above threshold in control counties
<b>Quality/ Efficiency</b>	50% of payments contingent on QI; will increase to 80% over demonstration period	50% of payments contingent on QI; will increase to 80% over demonstration period

# More Reforms Using Health IT Coming in Health Care Reform Legislation...

- Support for “Distributed Analysis Network” Infrastructure for Quality Measurement, Comparative Effectiveness Evidence, Safety Surveillance
- Accountable Care Organization Payment Authority for Medicare
  - » With authority for public-private collaborations
  - » With electronic performance reporting
- Other Payment Reforms, Changes in Competition Focusing on Value
  - » Bundled payments for episodes of care, reduced payments for readmissions, transparency, insurance exchanges