



## **Hearing before the Senate Special Committee on Aging “Patient-Focused Care: A Prescription to Reduce Health Care Costs”**

**Written testimony submitted by the Health Care Transformation Task Force  
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Chairman Collins, Ranking Member Casey, and Members of the Senate Special Committee on Aging: thank you for the opportunity to provide written testimony on innovative approaches to improving value in the health care system for older Americans.

The Health Care Transformation Task Force (“Task Force”) is a diverse group of over 40 private sector stakeholders across the industry – including providers, health plans, employers, and consumers – that support accelerating the pace of delivery system transformation. Together Task Force members share a common commitment to transform their respective businesses and clinical models to deliver better health through high quality care at reduced cost and aspire to have 75 percent of their business in value-based payment arrangements by 2020.

My commentary today focuses on how organizations are using effective and innovative strategies to improve care and lower costs for aging Americans, with a particular focus on Accountable Care Organizations.

First, I’d like to offer some background on value models. You may be familiar with the term Accountable Care Organization, or ACO for short – this refers to a health care organization that ties payments to quality metrics and the cost of care. ACOs have grown in popularity among health care organizations over the past several years, supported by programs that have been offered by the Center for Medicare and Medicaid Services and commercial insurers. ACOs remain the most prolific vehicle for value-based payments to-date: in 2017, there were more than 923 public and private ACOs covering approximately 32.4 million lives across the country.<sup>1</sup> In 2018, there are 656 Medicare ACOs that cover almost one-third of the entire Medicare Fee-for-Service population.<sup>2</sup>

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<sup>1</sup> Muehlstein, D. et al. Growth of ACOs And Alternative Payment Models In 2017. *Health Affairs*. Available at: <https://www.healthaffairs.org/doi/10.1377/hblog20170628.060719/full/>

<sup>2</sup> MedPAC June 2018 Report. Chapter 8: Medicare accountable care organization models: Recent performance and long-term issues. Available at: [http://www.medpac.gov/docs/default-source/reports/jun18\\_ch8\\_medpacreport\\_sec.pdf?sfvrsn=0](http://www.medpac.gov/docs/default-source/reports/jun18_ch8_medpacreport_sec.pdf?sfvrsn=0)

There is strong evidence to support that ACOs have had a meaningful impact on lowering costs. Recently released 2017 data from the Medicare Shared Savings Program, the primary program for Medicare ACOs, demonstrates that the federal government has generated \$314 million in net savings – *after* bonuses were paid out to participants. Gross savings to the program totaled \$1.1 billion. The 2017 results also confirm in practice what the industry has known to be true – that organizations which committed to the program early on are more likely to generate shared savings than their more junior peers. For example, ACOs that started the MSSP program in 2012 or 2013 created net savings of \$205 million, while ACOs that started in 2016 or 2017 generated \$68 million in losses.<sup>3</sup> These results show that with most good innovations, it takes time to realize potential.

ACOs have also had a significant impact on health care quality. A June 2018 report by MedPAC indicated that over 90 percent of risk-bearing Medicare ACOs met or exceeded quality standards. These ACOs also had strong patient experience scores and high-performing readmissions results.<sup>4</sup> A 2017 Office of Inspector General report indicated that ACOs outperformed fee-for-service providers on 81 percent of key measures such as screening for depression and risk of falling.<sup>5</sup>

Late last year, the Task Force conducted a study<sup>6</sup> of the 21 highest performing Medicare ACOs based on 2015 performance data. Among the most successful ACOs, we found that organizations focused on three key elements: 1) achieving a high-value culture; 2) developing strong population health management programs; and, 3) creating structures that can ensure continuous improvement in performance over time.

We found that the highest-performing ACOs first and foremost have a strong commitment to developing a culture that supports innovation and is committed to the mission of improving care delivery. That commitment must be unwavering in the face of multiple obstacles; changing culture takes time and requires effective leadership at many levels. Most of the successful organizations we profiled had previous experience managing financial risk before implementing an ACO model. They also had the support and commitment of executive leaders who saw the importance of investing in new models, as well as governance structures that are conducive to fostering a high-value culture (such as encouragement of innovation and feedback).

Organizations with high-value cultures understood the importance of engaging clinicians and care teams to accomplish shared goals, and demonstrated a commitment to practice education, support services, and compensation structures that reward continuous improvement. ACOs simply cannot succeed without truly engaged physicians and other health care practitioners who are committed to understanding how their practice patterns influence the goals of the ACO and serving as champions to help guide their peers. The delicate balance of aligning incentives is critical to getting all stakeholders on the same page driving toward success.

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<sup>3</sup> <https://www.naacos.com/press-release--more-medicare-acos-achieve-quality-and-cost-goals-in-2017>

<sup>4</sup> MedPAC June 2018 report.

<sup>5</sup> OIG. Medicare Shared Savings Program Accountable Care Organizations Have Shown Potential for Reducing Spending and Improving Quality. Available at: <https://oig.hhs.gov/oei/reports/oei-02-15-00450.asp>

<sup>6</sup> Health Care Transformation Task Force. Levers of Successful ACOs. 2017. Available at: <http://hcttf.org/2017-11-8-levers-of-successful-acos/>

In our research, we have seen that the most successful Medicare ACOs are those that have been in the program over the course of multiple years and have had time to learn how to manage risk. They may have started with similar commercial insurance agreements that gave them the experience and confidence necessary to effectively manage a shared savings program.

As I'm sure this Committee will appreciate, the crux of any successful payment program is top-notch care delivery. For ACOs, having very strong population health management programs is critical. These programs serve the essential function of identifying patients who are at-risk for or already have challenging or multiple medical conditions and acting swiftly to ensure that these patients receive the best, most personalized care possible to avoid unnecessary hospitalizations.

Effective population health management programs truly put the patient first by using tools and resources that facilitate personalized, proactive care. Vanguard health care providers risk-stratify patients using homegrown analytics models, electronic health record modules, and population health software; these high-tech processes are combined with expert recommendations from physicians on how best to provide treatment that is individualized to patient needs.

One example of how risk stratification works in practice is an ACO that organizes patients into four categories, from least to most intensive. Thirty-five percent of patients receive wellness and preventive care prompts, such as cancer screenings and vaccine outreach. About forty percent receive early disease management in response to emerging symptoms of chronic disease, such as Type 2 diabetes. The next twenty percent of patients are more frequent hospital emergency department utilizers; these patients are assigned to patient navigators who assist in discharge planning and complex care management for chronic illness. The remaining five percent of patients receive hospice or palliative care for late-stage illness.

The best population health management programs employ interdisciplinary care teams that typically consist of physicians, nurse care managers, pharmacists, social workers, and care guides or navigators. These structures are often flexible to best accommodate patient needs. In some instances, a social worker may be best equipped to interact most often with the patient, especially if the patient is struggling with social factors such as housing instability or access to transportation that directly contribute to his or her health status. Strong population health programs also partner with existing community resources and local public health departments to ensure that all facets of a patient's health challenges are addressed. Today, addressing social determinants of health is a concept that gets a lot of attention and rightly so, and maturing ACOs are increasingly focused on those factors as a way of caring completely for patients. Partnering with community organizations is critical to a comprehensive care regimen for individuals.

Many high-performing ACOs and providers have specific programs and resources that are geared toward chronic illness. The most ubiquitous programs focus on four primary chronic conditions: diabetes, congestive heart failure, chronic obstructive pulmonary disease (COPD), and chronic kidney disease. These conditions disproportionately affect aging and low-income Americans. Effective ACO-administered chronic disease programs rely not only on evidence-based disease treatment protocols, but also empower patients through education, clinical support, and assistive tools such as remote monitoring to help manage their own health.

Finally, we found that successful ACOs must have continuous improvement structures in place to drive value once the “low-hanging fruit” has been plucked. It is simply not enough for health care providers to change their business model in one go and coast. They must constantly reevaluate their performance and business structures. The most sophisticated organizations have dedicated data, actuarial, and performance improvement resources that are constantly managing change and looking for new opportunities to increase value. They partner with clinical leaders to address variation and inefficiencies in clinical workflow and patient outcomes, and find ways to reduce duplication in areas such as quality reporting that can contribute to physician burnout.

Successful organizations also tie performance to compensation. This is an area that is still in testing. Many health systems and physician groups are experimenting with how best to tie provider quality performance back to compensation. Some ACOs directly pass on shared savings to each participating provider through gainsharing arrangements. Challenges and complications can arise, however, as there is generally a lag in shared savings payments to the organization and when providers expect to be compensated for their performance.

All organizations should expect to run into challenges along the road to value. That’s why participation in shared learning opportunities is critical. The ability to share notes/compare data with peers, and access to organizations that are more advanced in their value models, can be tremendously helpful as ACOs and others navigate regulatory, financial, and cultural challenges. Shared learning collaboratives can also provide organizations with a better understanding of their performance relative to their peers. Regional quality collaboratives, such as the Wisconsin Collaborative for Healthcare Quality, and national consortiums, offer outlets for organizations that are interested in learning from peers and cross-industry partners. The Task Force serves this function for national collaborators.

In reality, there is no one-size-fits all approach to value-based health care. Yet, through our analysis of ACOs and our ongoing work to promote new value-based payment models, we’ve discovered that the key themes I just described are essential for organizations to successfully transition away from volume-driven, fee-for-service medicine.

To all of us in this room, we must remember that changing our health care system is not something that can be accomplished in one fell swoop. Rather, we are rebuilding brick by brick the foundation upon which our care is paid for and delivered. Not all innovation will be an immediate success, and it is incumbent upon on all to identify what holds promise and stay the course until meaningful change is achieved. The Task Force stands as a reminder of what can be accomplished when like-minded organizations reach across the negotiating table and work with their fellow health care stakeholders to develop and commit to implement new answers to old problems.

Chairman Collins, Ranking Member Casey, and members of the committee, thank you again for the opportunity to testify before you today. I welcome your questions.