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Accountable Care and Workers Compensation:

Are They Compatible?

First let's review the acronym glossary. Accountable Care Organizations (ACOs) were stimulated by the Patient Protection and Affordable Care Act (PPACA). A cousin of the ACO model is the patient-centered medical home (PCMH) model. And these, and similar delivery systems, are often described as value-based healthcare (VBH) models.

While similar to managed care models of yesteryear, VBH models comprise three critical elements:

- The medical entity bears financial responsibility for the health care needs of a defined population, employing shared savings and risk arrangements that "align the incentives" among all stakeholders.
- The entity coordinates and oversees the clinical provision of care across the continuum of all services required for the population being served.
- The entity provides measured outcomes relating to both cost and health, ideally achieving both medical expense reductions and superior clinical results.

It is recognized that successful ACOs require both a sophisticated administrative infrastructure to manage care effectively, as well as robust information technology systems that collect data seamlessly across the system and deliver meaningful reporting and analytics.

In the inaugural issue of the American Journal of Accountable Care, the authors describe their mission as follows:

> "In this time of contention, there seems to be a growing consensus among stakeholders that the traditional, volume-based, fee-for-service (FFS) care is an untenable strategy to deliver

> evidence-based care that is both fiscally sustainable and able to meet the clinical needs of Americans. As we look for a solution to an overspending, underachieving system, the concept of "accountable care" has received much attention as a potential mechanism to better align provider financial incentives with high-quality care."

ACOs have proliferated rapidly since their inception in 2010. As of June 2014, there are said to be 626 ACOs across the country, of which 329 have government contracts, 210 have commercial contracts, 74 have both, and 13 are in development. It is estimated that 20 million Americans are currently covered by ACO agreements. There is considerable variation in these statistics, as reported by multiple sources.

A recent article documents furious activity in this sector, involving major health payers such as Aetna, Cigna, United Healthcare, multiple Blues plans, and Humana, among others.

> Humana also reports that its ACO business, as broadly defined, is taking off. "Today we have well over 900 relationships with provider entities that we call 'accountable,' " says Renee Buckingham, enterprise vice president for the provider development center of excellence within Humana's healthcare services segment. That includes joint ventures, medical homes and integrated delivery systems. Of the total, approximately 100 or so relationships are commercial, according to Buckingham.

Structurally ACOs come in many configurations: "if you've seen one ACO, you've seen one ACO". They may be owned by hospitals, physician groups, or integrated systems. They may provide all services internally, or outsource some services to affiliated entities. The risk/savings may be shouldered by the entity as a whole, or flow downward to some or all participating providers.

Generally, ACOs and similar VBH arrangements are intended to provide comprehensive medical services, "population-based care". However, there are also initiatives underway which apply this approach to more granular sets of services, referred to as "bundles" or "episodes of care". Bundled care is sometimes considered to be a stepping stone toward fully accountable care for a defined population, i.e., a way station on the continuum from fee for service, to pay for performance, to shared savings and bundling, then ultimately arriving at the goal of full capitation.

> "Bundled payments encourage providers to collaborate on improving the efficiency and quality of individual care episodes, honing in on the unit cost of care. Two key features of the bundled payment create these incentives. First the lump sum payment is shared among participating providers, establishing mutual accountability. Second, the bundled payment is typically smaller than the sum of historic individual payments, generating upfront savings for the payer. As a result, providers can only succeed under bundled payments by reducing input costs and growing volumes to offset the reimbursement cut per case.
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> In a bundled payment program, providers ultimately succeed by reducing input costs and improving quality during individual episodes of care. As a result, hospitals will develop gainsharing models to reward physicians for standardizing high-cost implantable device and care protocols. If readmissions are included in the bundle, hospitals will work to streamline

> patient handoffs across the care continuum and engage patients post-discharge to reduce readmission risk."

The Centers for Medicare & Medicaid Services (CMS) has taken the lead in establishing a program of this type:

> "On January 31, 2013, the Centers for Medicare & Medicaid Services (CMS) announced the health care organizations selected to participate in the Bundled Payments for Care Improvement initiative, an innovative new payment model. Under the Bundled Payments for Care Improvement initiative, organizations will enter into payment arrangements that include financial and performance accountability for episodes of care. These models may lead to higher quality, more coordinated care at a lower cost to Medicare.
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> Traditionally, Medicare makes separate payments to providers for each of the individual services they furnish to beneficiaries for a single illness or course of treatment. This approach can result in fragmented care with minimal coordination across providers and health care settings. Payment rewards the quantity of services offered by providers rather than the quality of care furnished. Research has shown that bundled payments can align incentives for providers – hospital, post-acute care providers, physicians and other practitioners – allowing them to work closely together across all specialties and settings."

Of the 48 bundled packages established by CMS to date, 14 of these deal with orthopedic procedures commonly required in workers compensation settings. For example one package is entitled "cervical spine fusion" which encompasses DRG groups 471-473, and could include all hospital services as well as all related physicians (surgeon, anesthesiologist, radiologist, etc.).

The drawback of episodic arrangements is that while they can favorably impact the quality and cost metrics of each specific bundle, they do not per se address the utilization/frequency of these services, i.e., how many cervical fusions are being performed in the population.

Early results of VBH arrangements are promising, though not consistently so, both within CMS shared savings programs, and as reported by commercial payers. Total medical expenses have been reduced, as well as the rate of hospital admissions and emergency room visits.

> "A March 2013 Commonwealth Fund report, exploring the experiences of seven ACOs, found that the most advanced ACOs saw reductions or slower growth in health care costs and had anecdotal evidence of care improvements. The ACOs in the report that had been at financial risk long enough to see results have cut costs, primarily from reduced hospitalizations, lower spending per hospitalization and reduced spending on specialty and ancillary care. Newer ACOs lacked enough financial data to cite concrete results, but some saw improvements in utilization rates, such as fewer inpatient days, lower length of stay and greater patient engagement."

An exhaustive Rand Corporation research report evaluated the success of three types of VBH models: pay for performance, ACOs, and bundled programs, and concluded that definitive results are simply not available at this time.

> "VBP programs are natural experiments and inherently difficult to evaluate because program sponsors rarely withhold the VBP intervention from a matched group of providers to see what would have occurred absent the intervention. There are many weaknesses in the methods often used to evaluate P4P (and now the broader class of VBP programs), including reliance on pre-post comparisons with populations of providers that are substantially different from the treatment group, and failure to account for other factors that may be contributing to the observed results.
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> The application of performance-based payment models represents a work in progress regarding how best to design VBP programs to achieve desired goals, the optimal conditions that support successful implementation, and provider response to the incentives. We believe that continued innovation is desired at this early stage of VBP development and implementation. Concerted efforts will be required to ensure that the lessons learned from these experiments are identified and disseminated to advance the use of VBP as a strategy for improving federal and private health care programs."

Do these alternative medical models offer opportunities to redesign the prevailing model of delivery and financing in workers compensation? It would seem that bundled arrangements would be easier to implement than population-based models, and furthermore they would more closely match the nature of WC events which are inherently episodic, not holistic.

Several barriers to WC application of these models exist. Historically, WC has been a volume-driven, fee-for-service model, and expectations and attitudes would need to be reformed. A pattern of micromanagement of all medical services would need to be altered, by increased delegation to provider entities. And the plethora of state regulations, dealing with reimbursement and direction of care, among others, would need to be overhauled to facilitate these approaches.

Specific recommendations offered include:

> **Providers/ACOs**: Be receptive to closer partnership with workers compensation and group health insurers. Be prepared to embrace additional risk sharing and the occupational medicine expertise that will be required to maintain fast return-to-work.
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> **Workers compensation insurers**: Set up the proper risk sharing models, reduce the administrative burden, stop micromanaging physicians, and instead build networks that include only physicians who have proven they can support good health outcomes. Evaluate closer partnerships with healthcare insurers and employers, especially those that have integrated.
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> **Regulators**: Consider accelerating adoption of outcome-based arrangements in workers compensation by providing legislative incentives for these programs.

Despite the bumps along the way, many observers feel that the future shape of medical care delivery and financing is inevitable.

> "The development of the accountable care movement will be determined by early results. The majority of ACOs are using shared savings models, and most are committed to evaluating their financial returns for 2 to 3 years before moving away from these payment arrangements. ACO leaders speak of a desire to improve the value they provide, but they are hesitant to adopt any wholesale movement away from FFS-based billing as they are not fully convinced that full provider risk and capitation/bundling is the inevitable conclusion of the accountable care movement. In the short term, however, providers are continuing to experiment with new payment models and new approaches to providing and coordinating care. The end result of the ACO movement, particularly relating to provider risk and reimbursement, is still undecided, but the consensus among these organizations is that the value-based focus of accountable care is here to stay."

Interesting times lie ahead.

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At Broadspire, Dr. Lazarovic directs the Medical Department which produces clinical guidelines and criteria that support sound medical claim and case management practices; participates in analysis, reporting and benchmarking of outcomes, and quality improvement initiatives; develops educational and training programs that update adjusters' and nurses' clinical knowledge and skills; and provides expertise which enhances the medical bill review process. Additionally, the Medical Department operates a comprehensive in-house physician review (peer review) unit that contributes to effective utilization and case management decisions, promotes the appropriate use of medical services, and facilitates timely return-to-work through communication with treating physicians.

The Medical Department also carries out and publishes original research and development on issues relevant to workers compensation and disability.

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