

Accountable Care Organizations An Introduction

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What is an Accountable Care Organization (ACO)?

- A provider-led organization whose mission is to manage the full continuum of care and be accountable for the overall costs and quality of care for a defined population
- Normally physicians and hospitals will accept joint responsibility, but will include other providers such as home health and long term care.

Three components of ACO infrastructure

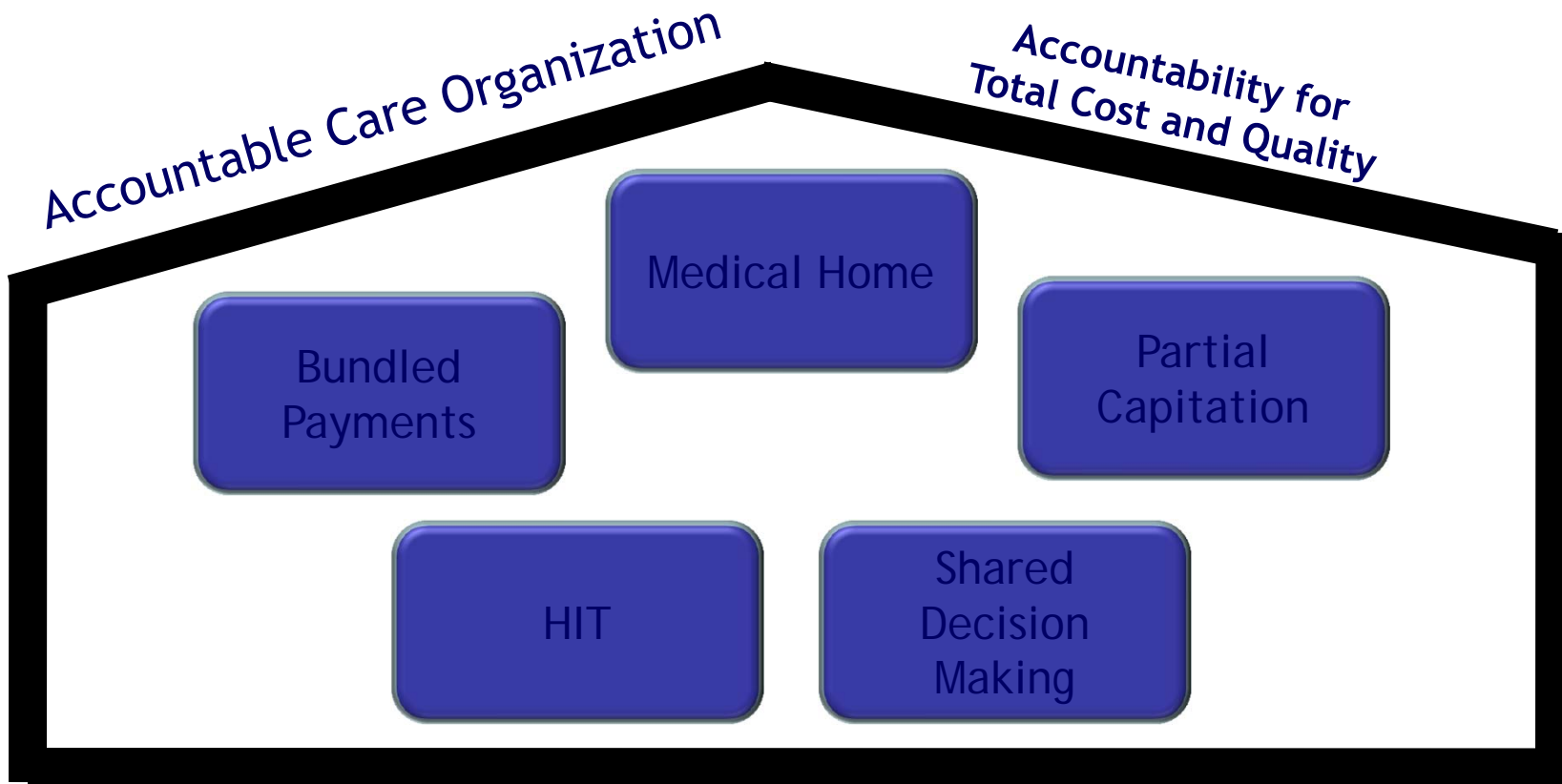


- Local Accountability for Cost, Quality, and Capacity

- Shared Savings

- Performance Measurement

The ACO is the overarching structure within which other reforms can thrive



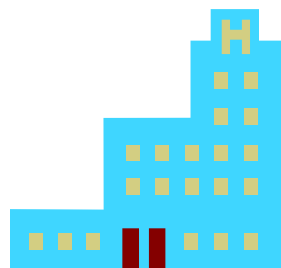
What providers comprise an ACO? It varies.

Accountable Care Organization

Primary Care



Hospital



Specialists



Other Possible Components:

Home Health

Mental Health

Rehab Facilities

ACOs will look very different, but a few characteristics are essential

1

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

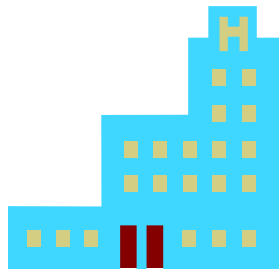
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Are of a sufficient size to support comprehensive performance measurement

3

Capable of internally distributing shared savings payments

No Lock In: Patients assignment to ACO



Providers sign agreement to participate with ACO

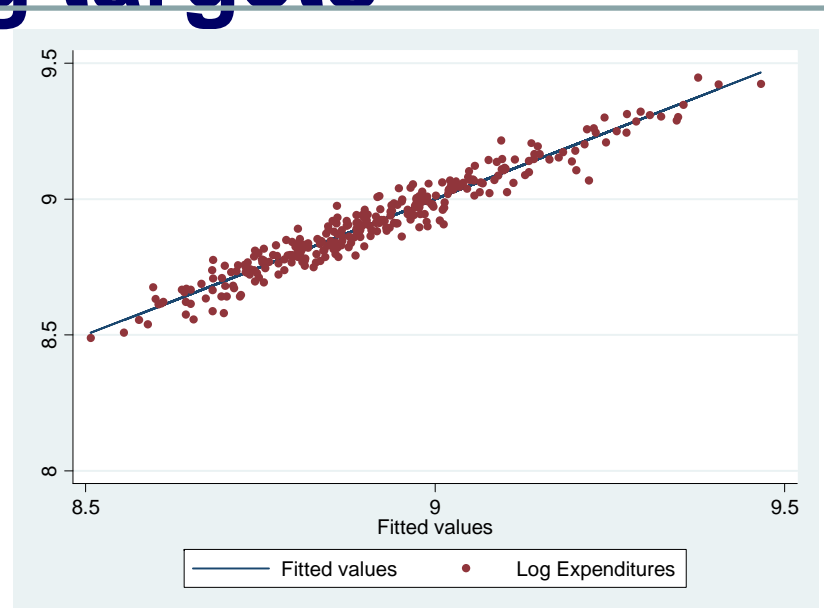
(PCPs must be exclusive to one ACO; Specialists can be part of multiple ACOs)



Patients are assigned to their PCP based on the majority of their outpatient E&M visits

Calculating savings based on spending targets

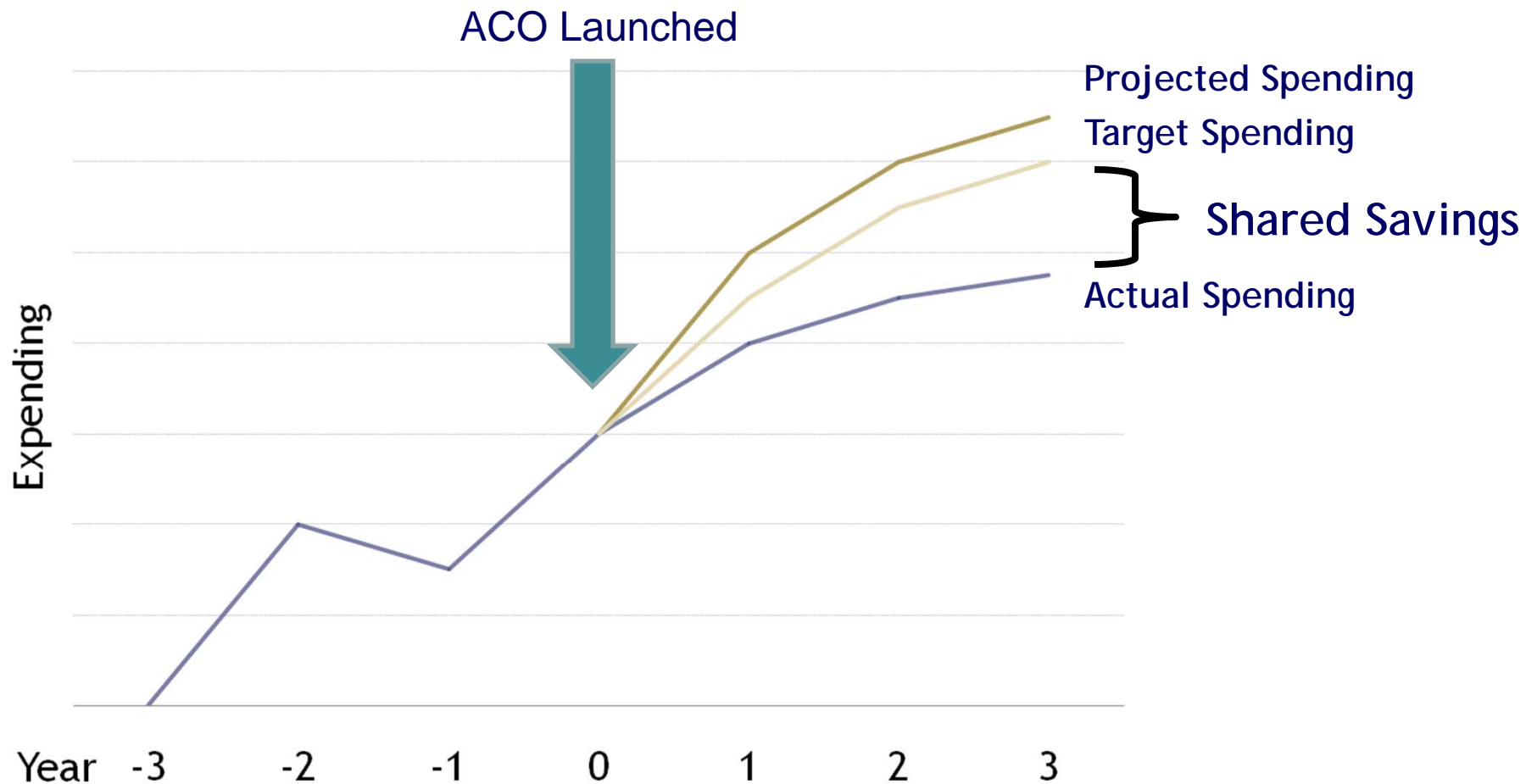
- Patients are assigned to physicians in the ACO
- 3-year historical average of total expenditures for ACO is calculated
- Expenditures for ACO are predicted
- Expenditure target is negotiated between the ACO and its payers.



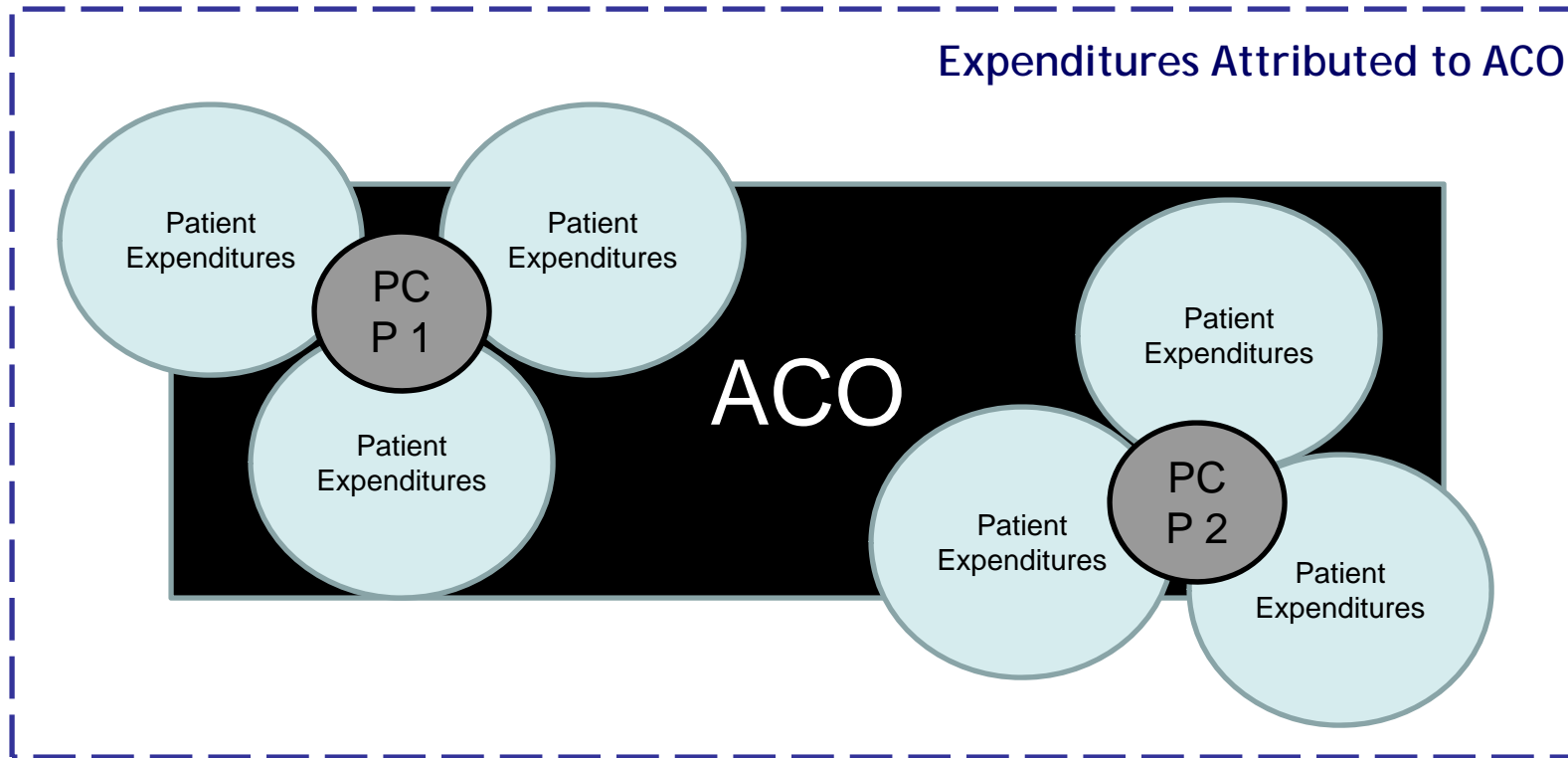
Predicted and actual log age-sex-race Medicare expenditures, 2003-05, for EHMSs with at least 5000 people.

$N = 287$, $R^2 = .94$, Error = .04 Percent

Calculating savings based on spending targets

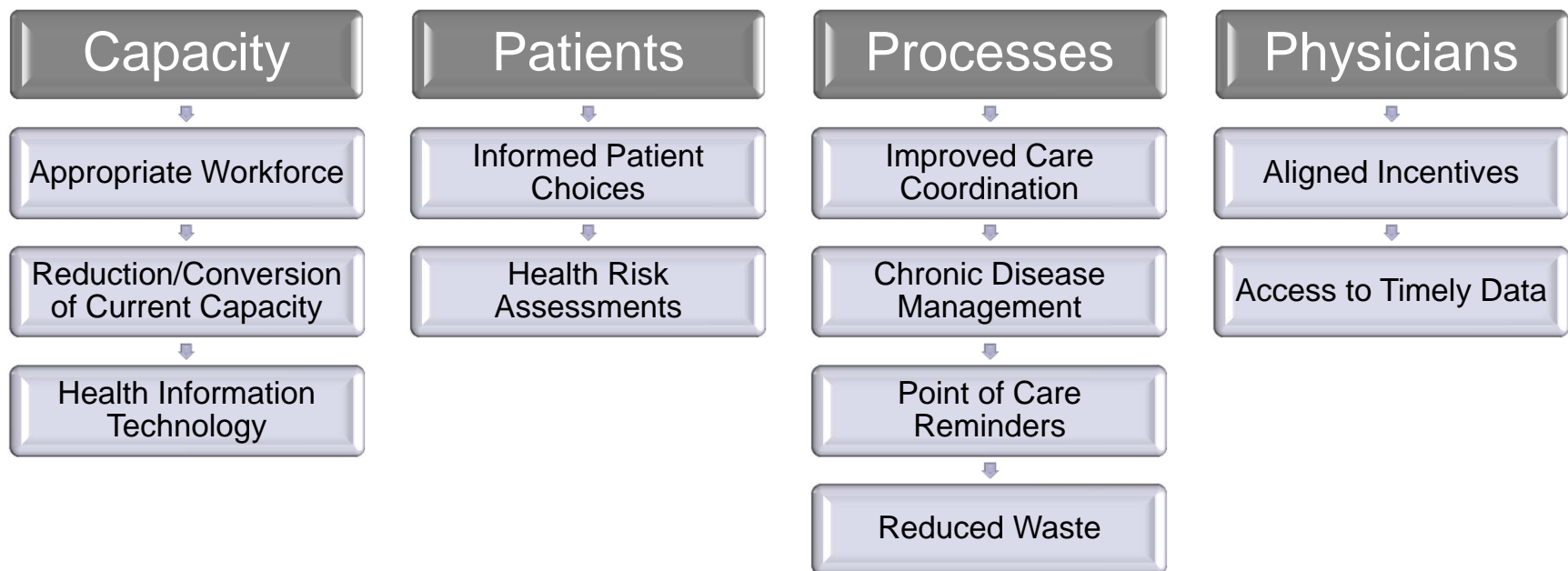


ACO is responsible for all patient expenditures



How do ACOs reduce expenditures?

- Through systematic efforts to improve quality and reduce costs across the organization:



Multiple initiatives within the ACO model:

\$800M (Target Expenditures)

- \$160M (20% Capitation)
 - \$365M (Traditional Fee for Service Payments)
 - \$115M (Bundled Payments for Specific Conditions)
 - \$150M (PMPM Payments for Medical Home)
-

\$10M (Available Shared Savings)



(80/20 agreed upon split)



\$8M to the Providers

\$2M to the Payers

Local accountability is the goal

- Current proposals (bundled payments, chronic disease management, pay-for-performance) while important, do not promote accountability for per capita cost, quality and capacity.
- Bonus models must be large enough to offset incentives in FFS
- **In the ACO model, providers are accountable for cost and quality**
 - Shared savings payments are based on total patient expenditures and quality targets

Why “Accountable Care”?

- Need to merge provider system reforms with payment system reforms
- Needed bridge strategies and new approaches with payors
- Fulfill vision for patients, community, and providers for Accountable Care, current processes will need to change
- Medical Home is one potential new process

Care Coordination:

- Intensive management of high risk patients (recurrent admissions/ED visits)
- Outreach to patients with defined diagnoses that need more attention (DM, HTN, Asthma, CHF)
- Enriched visits with education sessions
- Ensure appropriate screening is performed

Medical Home

- Comprehensive primary care
- Imperative for wellness
- Management of chronic disease
- Elimination of unnecessary potentially harmful care
- Avoid preventable diseases
- Stay healthy longer
- Avoid hospitalization, ED visits, costly diagnostic work-ups

Medical Home

- Nurse case manager in office
- Disease registries
- Detailed clinical outcome reporting
- Team-based care using guidelines and good coordination & communication
- Increase patient involvement via Internet access for questions, medications, appointments, record access

Medical Home

- Fee-for-service payment not sufficient to support this needed change
- Payments need to promote community and population focus, quality, service, and cost management
- Grow primary care “panels”
- Encourage coordination of care with specialists who are not necessarily part of the PCP’s physician group

Potential Performance Measures

- Diabetes
 - A1C, LDL, BP control
 - Eye Exams, Kidney screening
- CAD
 - LDL control
 - Aspirin prophylaxis
- CHF
 - Beta-blockers of LV dysfunction
 - BP and LDL control
- Hypertension
- Population Health
 - Immunizations, BMI, medication reconciliation, smoking cessation

Potential Performance Measures

- Overuse
 - Antibiotic use, URIs, Bronchitis
 - Back pain imaging studies
- Population Health
 - Breast, Cervical, Colon cancer screening
 - HbA1C management
 - Cholesterol management
 - Beta-blockers for AMI
- Safety
 - Drug interactions in elderly
- Care Coordination
 - 30 day re-admits AMI, CHF, pneumonia

Potential Performance Measurement Process

- Medicare Compare Data
- HCAHPS Patient Experience Surveys
- Claims-based measures, broadly endorsed
- Measure set will be modified in subsequent years to reflect advances in measure development and collection
- Interest in utilization and medical management outcomes but need to evolve there
- Need registries

Payment Strategies for Getting Started

Funding Strategies

- Population and chronic disease management
- Move up the payor chain and change relationships with payors- collaboration and co-branding
- Medical home - philosophy of care and payment mechanisms
- Medicare Advantage – take on risk - supports medical home
- Gainshare to Capitation - ACOs link provider and payment reforms

Medicare Shared Savings Program

- Proposed rule released March 31, 2011
- Final rule just released last week
- Goal to lower the growth in healthcare costs for Medicare beneficiaries while still meeting certain quality of performance standards
- Patient and provider participation is **VOLUNTARY**

Incentive for Medicare to move to ACO's

- Over 50% of beneficiaries have five or more chronic diseases
- One in seven patients admitted to a hospital has been subject to a harmful medical error
- One in five patients discharged from a hospital are re-admitted within 30 days
- Projected savings is \$960M over 3 years

Medicare Definition of an ACO

- Group of providers and suppliers of services working together to coordinate care for the patients they serve with Original Medicare
- Goal – deliver seamless, high quality care for Medicare beneficiaries

Quality Performance Standards

- Patient/Caregiver experience of care
- Care coordination
- Patient Safety
- Preventive Health
- At-risk population/frail elderly health

Provider Interest

- Many providers were not sure whether to participate due to uncertainties in proposed rule
- Appears to be increased interest under the final rule
- Still concern could not earn back their initial investment to get the ACO up and running
- Demonstration project has not shown that this payment methodology will work

Medicare Pioneer ACO

- Aimed at more mature ACO's
- Traditional Clinics have not show much interest
- Current belief is about 30 organizations have signed on
- Awaiting list of participating groups

CMS Innovation Center

- Bundled Payment Initiative
 - Model 1 – Inpatient stays, all MS-DRGs, discounted IPPS payments to hospitals, allowed to share payments with physicians
 - Model 2 – Inpatient stay and post acute services, specific MS-DRGs, specified time frame, covers many types of providers, actual expenditures vs targeted expenditures

CMS Innovation Center

- Bundled Payment Initiative
 - Model 3 – Post Acute Services only, covers many providers, specified diagnosis and time frame, actual expenditures vs targeted expenditures
 - Model 4 – Prospective payment for services where a single payment must be shared among providers

CMS Innovation Center

- Bundled Payment Initiative
 - Non-binding Letters of Intent Deadlines
 - Model 1 was October 6
 - Models 2-4 due November 4
 - Application Deadlines
 - Model 1 is November 18th
 - Models 2-4 are due March 15th
 - Claims Data Request also due November 4th

CMS Innovation Center

- Comprehensive Primary Care Initiative
 - Requires payer participation
 - Only five to seven markets nation-wide
 - Medicare will begin to pay primary care physicians a monthly payment for managing patient care
 - Manage care for patients with high health care needs
 - 24/7 access for patients
 - Provide preventive care
 - Engage patients & their families to participate in care
 - Coordinate with other providers

Issues Our ACO Is Facing

- Reliable timely information sufficient to drive rapid improvements (ex. registries, clinical outcomes, costs)
- Balancing the need to reduce hospitalizations with managing hospitals (ie. success means parasitizing yourself)
- Managing the transition from FFS and in-patient focus to something else (ie. the gain share may not offset the revenue loss)
- ACO must be large enough to distinguish improvement from random variation

Our Early Challenges and Risks

- Changing physician behavior- being more patient-centered, adopting new practice styles, being accountable for waste and evidence-based care
- Defining waste
- Large portion of practice needs to be in ACO
- Lack of large regional employers- hard to engage large groups of patients in the changes they too need to make
- Communities and patients not ready to accept changes in their care- the rationing argument (ex: palliative care)