Accountable Care Organizations and You

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Goals

- At the completion of this presentation the attendee will understand and have gained knowledge concerning the background, definition and current status for Medicare and Private Payer ACO.

The Accountable Care Organization
Specific Objectives

- The reasons behind healthcare reform
- The two part response of healthcare organizations
  - Enhance access and quality
  - Reduce cost per patient
- The definition of a Medicare Accountable Care Organization and recent rule updates
- The application of the ACO concept the private sector
- The requirements to create an ACO: what you need to do
Rationale for Health Care Reform

- Healthcare in the US is unaffordable – and has been for some time
- Disparity in healthcare in the US
  - Insurance
  - Access
  - Outcomes
- Need to reduce cost
  - Eliminate waste
  - Reduce per-unit cost

National Health Expenditure (NHE)

- 2009 NHE grew 4% : $2.5 Trillion
  - $8,086/person
  - 17.6% Gross Domestic Product
- Expenditures in 2009
  - Medicare $502 Billion (7.9%)
  - Medicaid $374 Billion (9.0%)
  - Managed $801 Billion (1.3%)
  - Self-pay $299 Billion (0.4%)
Projected NHE 2009-2019

- Growth in NHE ~ 6.1%/year
- Proportion of Healthcare in GDP ~ 19.3% in 2019

Projected Healthcare Expenditures
### Healthcare Spending

**Why so high?**

- Higher prices for the same health care goods and services
- Significantly higher administrative overhead costs
- Use of high-cost, high-tech equipment
- “Defensive Medicine”

### Healthcare Spending: Driven by Procedures

[Graphs showing healthcare spending trends by procedures from 1970 to 2004]
Healthcare Spending
Unrelated Factors

- Aging of population
- Better quality
- Better health outcomes

US Healthcare Patients

Fig. 1. Two-Year Average Percentage of Uninsured by State: 2008-2009

“It is clear that the nation will not be able to afford adding an estimated 30 million newly insured to the Medicaid program by 2020 and an estimated 76 million baby boomers to the Medicare program by 2030 without reducing the per-unit cost of care to the beneficiaries.”

Kaufman, Hall and Associates, August 2011

Challenges for Physicians and Healthcare Across all sectors

- Make healthcare more affordable
  - Focus on access and mission
  - Provide a quality product that payers can afford
  - Reduce per-unit cost
- Reduce utilization of services
  - Unnecessary tests, readmissions, admissions
  - Implies coordination of care
- Care model
  - Accountable Care Organization
<table>
<thead>
<tr>
<th>The Accountable Care Organization (ACO)</th>
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<tbody>
<tr>
<td>Principles</td>
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<tr>
<td>Definition</td>
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<td>Rules and Regulations</td>
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<table>
<thead>
<tr>
<th>Medicare Options</th>
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<tbody>
<tr>
<td>▪ CMMS Medicare Shared Savings Program [opportunities to participate going forward]</td>
</tr>
<tr>
<td>▪ CMMI ACO Pioneer Model [deadline passed]</td>
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<tr>
<td>▪ CMMI Bundled Payment [letters of intent must have been filed 10/6 or 11/4]</td>
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<tr>
<td>▪ Comprehensive Primary Care Initiative [letter of intent likely filed at statewide level]</td>
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<tr>
<td>▪ Other Opportunities</td>
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Five Foundational Principles of Value-Based Purchasing (e.g., ACO)

- Improve Health of the population
- Provide efficient, evidence-based, personalized care
- Achieve high level of patient satisfaction
- Implement measures for above
- Deliver entire continuum of services within a defined budget

Meet Your Newest Medicare Beneficiaries

Happy 65th Birthday!

Donald Trump  Char  Sylvester Stallone

Liza Minnelli  Dolly Parton  Pat Sajak

Source: Health Care Advisory Board interviews and analysis.
Overview & Definition of Medicare ACO

- Preceded by the Physician Group Practice Demonstration (2005-2010)
- Authorized by the Affordable Care Act
- Currently in the demonstration project stage
Definition—Medicare ACO

- Definition of Medicare ACO—generally defined as a local healthcare organization with a network of providers—primary care physicians, specialists, and hospitals—that are accountable for the cost and quality of care delivered to a particular population.

The Three “AIMS” of Reform

- Aim 1: Improve Health of Population
- Aim 2: Improve Quality of Care for Individuals
- Aim 3: Slow Growth in Total Cost of Care
### Purpose of Medicare ACO

- **Current Purpose**—to deliver more efficient and coordinated care that is rewarded for achieving benchmarks
- **Eventual Purpose**—to accept global (capitated) payment while meeting performance benchmarks; and to distribute funds to participating providers

### Evolution of Financial Model

- Fee-for-service
- Bundled Payment
- Shared Savings
- Shared Risk
- Global Payment (Capitation?)
Accountable Care Organization

- How does the ACO concept differ from the previous “HMO” concept?
- “Deja-vous all over again” Yogi Berra
  - Isn’t this just a “capitation” initiative again, which failed earlier?

<table>
<thead>
<tr>
<th>HMO</th>
<th>ACO</th>
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<tr>
<td>Provides specified services</td>
<td>Provides evidence-based care</td>
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<tr>
<td>for predetermined payment</td>
<td>with value-based reimbursement</td>
</tr>
<tr>
<td>Financial outcomes linked</td>
<td>Financial outcomes</td>
</tr>
<tr>
<td>based primarily on</td>
<td>linked with quality</td>
</tr>
<tr>
<td>operational performance</td>
<td>and member satisfaction</td>
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<tr>
<td>Incentives to ration care</td>
<td>Incentives to provide</td>
</tr>
<tr>
<td></td>
<td>evidence-based care</td>
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<tr>
<td>ACO rules issued March 2011</td>
<td></td>
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<tr>
<td>-----------------------------</td>
<td></td>
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<tr>
<td>▪ 5,000 beneficiaries (minimum)</td>
<td></td>
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<tr>
<td>▪ Retrospective assignment-plurality of services provided to PCP physicians</td>
<td></td>
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<tr>
<td>▪ PCPs only participate in one ACO</td>
<td></td>
</tr>
<tr>
<td>▪ Data available only for patients seen</td>
<td></td>
</tr>
<tr>
<td>▪ Patients have to “opt in”</td>
<td></td>
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<tr>
<td>▪ 65 measures in 5 “domains”</td>
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<table>
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<tr>
<th>ACO Final Rules—10/20/11</th>
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<tr>
<td>▪ Quarterly preliminary prospective assignment</td>
</tr>
<tr>
<td>▪ PCPs may be in more than one ACO</td>
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<tr>
<td>▪ Plurality of services can include specialists, NP, PA, CNS for assignment purposes</td>
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<tr>
<td>▪ Data will be shared for all patients on prospective list</td>
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<tr>
<td>▪ Measures reduced to 33 in 4 “domains”</td>
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<tr>
<td>▪ Pay for reporting vs. performance ramps up more slowly</td>
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### Governance of ACO

- Governance body required, with required proportional representation
- Must be able to receive and distribute payments to participating providers and suppliers
- Separate legal entity not required, but may occur in many cases

### Legal/Regulatory Framework

- Laws potentially implicated include Anti-Kickback Statutes, physician self-referral, federal Civil Monetary Penalty, anti-trust, insurance and tax laws.
- FTC statement—summarized—cannot fix prices, but can join together to improve patient care and lower costs
ACO Development Challenges

- Start-Up Costs and Investments in Capacity
- Fee-for-Service payments deteriorating faster than ramp-up of value-based payment
- Deciding on initiatives

ACO Delivery Challenges

- Primary Care & Specialty Independent Practices—align with a health care system? Which ACO’s (AHP’s) to join?
- Shortage of primary care capacity
- Alignment decisions may create winners and losers.....but decision path is unclear
- Capacities for health improvement and care coordination crucial—culture CHANGE!!!
ACOs in the Private Sector

- ACOs for private payers (insurance companies, self-insured employers) do not have any formal structure.

- At Ohio State, we may utilize “Accountable Health Plan” as the term for employer-based ACOs.

Employers and Payers as Key Drivers

- Less than half of employers familiar with ACOs and value-based purchasing.

  ⬆️

  ------Major Gap------

  ⬇️

- Employer expectations will ramp up faster than health systems can deliver.
Employers and Payers as Key Drivers

- Quality of care is more important to employers than managing cost
- But, managing cost is a “close second”
- Transparency from plans and providers is critical

Employers & Payers as Key Drivers

- Employers and Payers have “enrolled” populations, not “attributed” populations
- Employers and Payers can provide great impetus for member engagement, health improvement
- Outcome measures, satisfaction measures, and payment methodologies can be developed
Is an ACO Right for my Organization and Practice?
Critical Steps for the Creation of an ACO

- Leadership
- Integration
- Critical mass of PCPs and patients
- Cultural Change
  - Coordination of Care
  - Evidence Base Practice
- Health Information Technology
  - EMR
- Financial Expertise
- Experience with outcome based contracts

What are the national trends?

- 49 percent of new physicians are hospital-employed
- 65 percent of established physicians who change employment become hospital-employed

Source: MIMA Physician Compensation and Production Survey Report
Funds Flow in ACO Shared Savings Model

![Graph showing funds flow in ACO Shared Savings Model](image)

Source: The Family Physician’s ACO Blueprint for Success, AAFP 2011

CMS Center  ACO Readiness Domains

- Organizational Goals, Management and Governance
- Improving Care Delivery to Improve Quality and Reduce Costs
- Effective Use of Health Information Technology (IT) and Data Resources
- Ability to Assume and Manage Financial Risk
## Competency #1 – Organizational goals, management and governance – implementation steps

- Planning group with hospital and physician leaders – lay out a plan
- Assess level of interest and trust and market opportunity
- Create a common vision
- Create a governance structure and business plan
- Educate leaders and the broader physician community – faculty
- Assess where the rest of the community is and who you may invite to participate

## Culture Transformation – helping people to think differently

- Team based care
- Flag high risk patients in the system
- High risk disease education expanded and open to everyone – CHF, COPD, Diabetes, CAD, etc
- Protocols to get labs, etc. back to Patients
- Quality/cost/utilization/patient satisfaction
- Need leadership and education on how to make this happen
## Transformation

<table>
<thead>
<tr>
<th>Current</th>
<th>ACO System</th>
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<tbody>
<tr>
<td>• Fragmentation</td>
<td>• Integration</td>
</tr>
<tr>
<td>• Adversarial relationships</td>
<td>• Cooperation and</td>
</tr>
<tr>
<td>• Focus on “doing”</td>
<td>• Focus on a population</td>
</tr>
<tr>
<td>• One-to-one care</td>
<td>• Team based care</td>
</tr>
<tr>
<td>• Gatekeeper</td>
<td>• System management</td>
</tr>
<tr>
<td>• Perverse financial incentives</td>
<td>• Aligned incentives</td>
</tr>
<tr>
<td>• Focus on volume and intensity</td>
<td>• Focus on quality and efficiency</td>
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## Competency #2 – improving care delivery to increase quality and reduce costs – things to do now

- Risk evaluation and stratification of patients
- Conduct a PCP Strategic Plan and initiate a Medical home Model
- Admission management (Observation or Inpatient)
- Care coordination plan
  - Access
  - Readmission
- Evidence Based protocols (e.g. Imaging)
- Generic drug use
- Evaluate pricing
### Competency #3 – Effective use of health information technology and data resources

- Optimization of EMR
- **Data Analysis** – business intelligence
  - Build or buy
  - Develop RFP
  - Negotiate contract
  - Implement
- **Decision support to providers**
  - At point of care
- HIE – hospitals, physicians, payers, and others

### Potential data analysis companies

- Intelligent Health Care
- Phytel
- AMGA – Anecta product
- Well Centive
Competency #4 – Ability to Assume and Manage Financial Risk

- Historical costs of care need to be analyzed in detail for enrolled/attributed/assigned population
- Develop risk models and business plans
- Define your own risk models for payers
- Questions to answer
  - Who capitalizes the infrastructure improvements?
  - Who takes the risk for losses?
  - Who gets the savings?

ACO READINESS ASSESSMENT

- OVERALL READINESS
- Assume Financial Risk
- Health IT
- Quality to Reduce Cost
- Management

Target

[Bar chart showing readiness scores for each category with AMC and Ideal indicators]
The Accountable Care Organization and You

### Summary

- We are challenged to make healthcare more affordable
  - Focus on access and mission
  - Provide a quality product that payers can afford
  - Reduce per-patient care episode
- We must improve utilization of services
  - Reduce unnecessary tests, readmissions, admissions
  - Develop models for coordination of care
- Potential new care model
  - Accountable Care Organization

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### Learning More about ACOs

- [https://acoregister.rti.org/](https://acoregister.rti.org/)