

Accountable Care Organizations

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Objectives

- **To understand rising health care costs.**
- **To understand how demographics impact health care costs.**
- **To understand drivers of health care costs.**
- **To become familiar with newer models of care delivery – volume versus value based care.**
- **To understand Accountable Care Organizations.**
- **To understand new payment structures within an Accountable Care Organization**

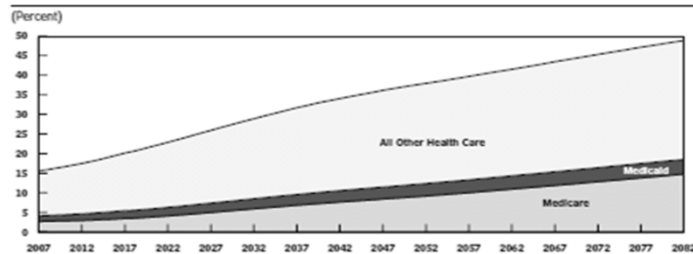
Contributors to Health Care Costs

- Demographics
- Public Sector Costs
- Private Sector Costs
- Physician Factors
- Administrative Factors
- Patient Factors/Satisfaction

Rising Health Care Expenditures

- The US spends 17.3% of GDP on healthcare
- Medicare and Medicaid spending projected to exponentially increase
- CBO projects that 49% of GDP will be spent on healthcare by 2082

Projected Spending on Health Care as a Percentage of Gross Domestic Product

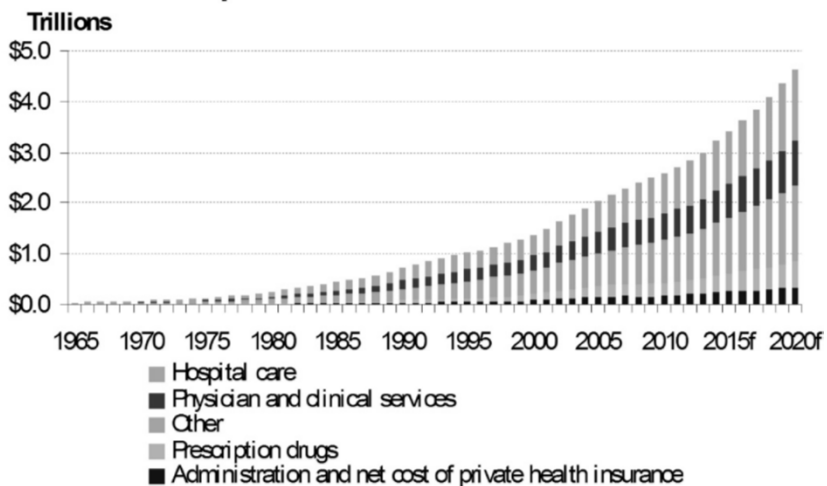


Source: Congressional Budget Office.

Note: Amounts for Medicare are net of beneficiaries' premiums. Amounts for Medicaid are federal spending only.

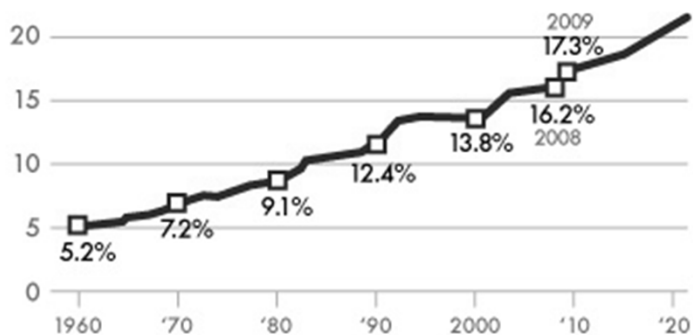
Projected Spending on Health Care as a Percentage of Gross Domestic Product. Congressional Budget Office Long-Term Outlook for Health Care Spending report, November 2007 (Figure 4, Page 13). CBO Web Site. <http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/87xx/doc8758/11-13-lt-health.pdf>. Accessed January 31, 2012.

Annual U.S. Expenditures on Healthcare

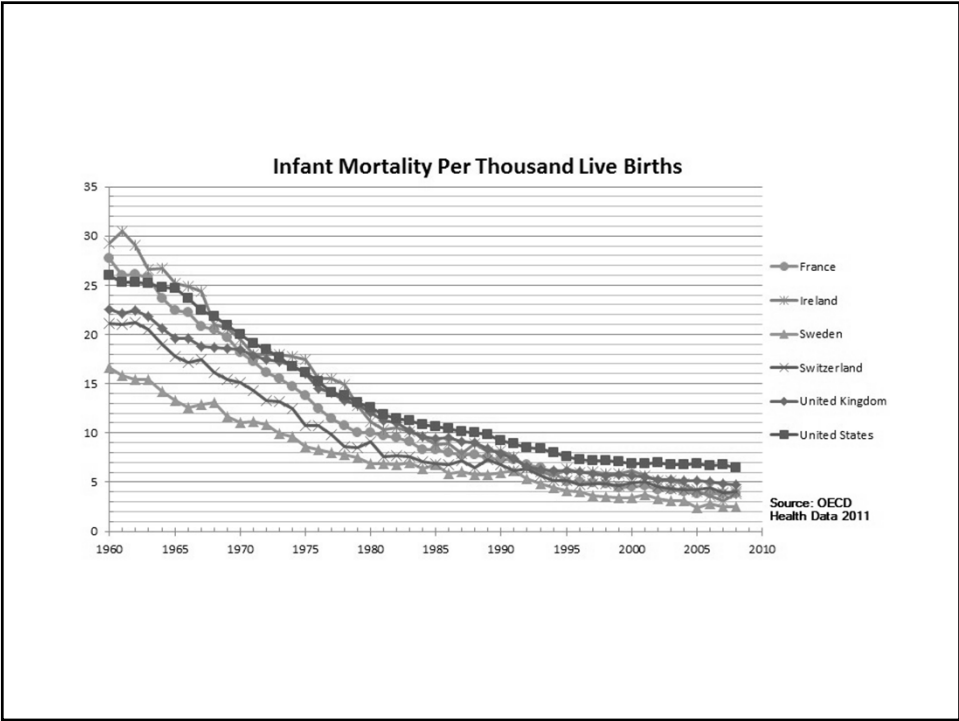
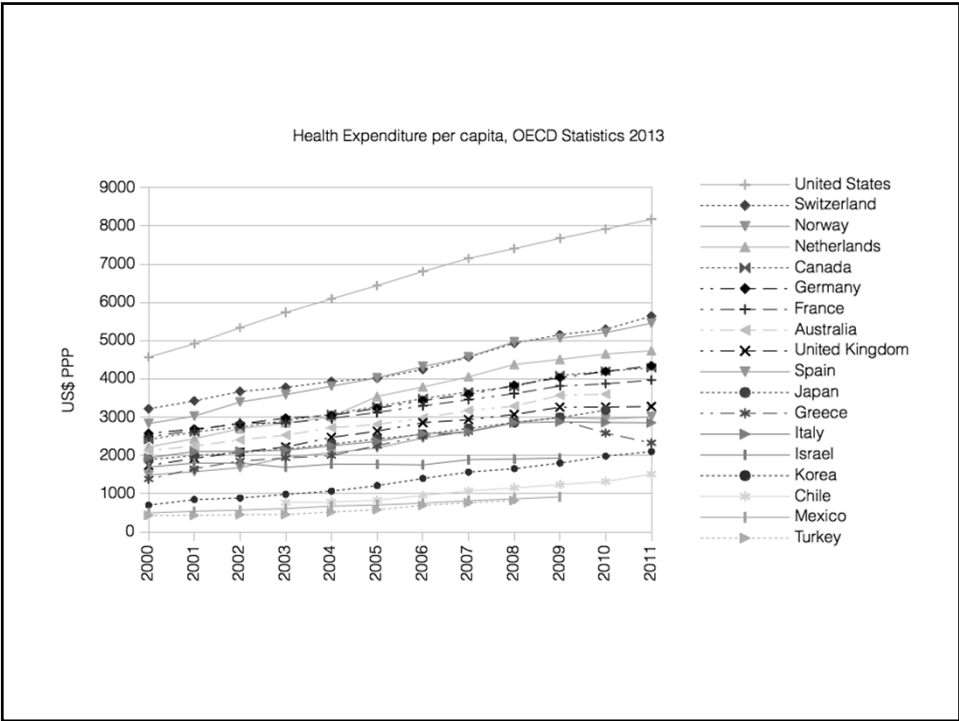


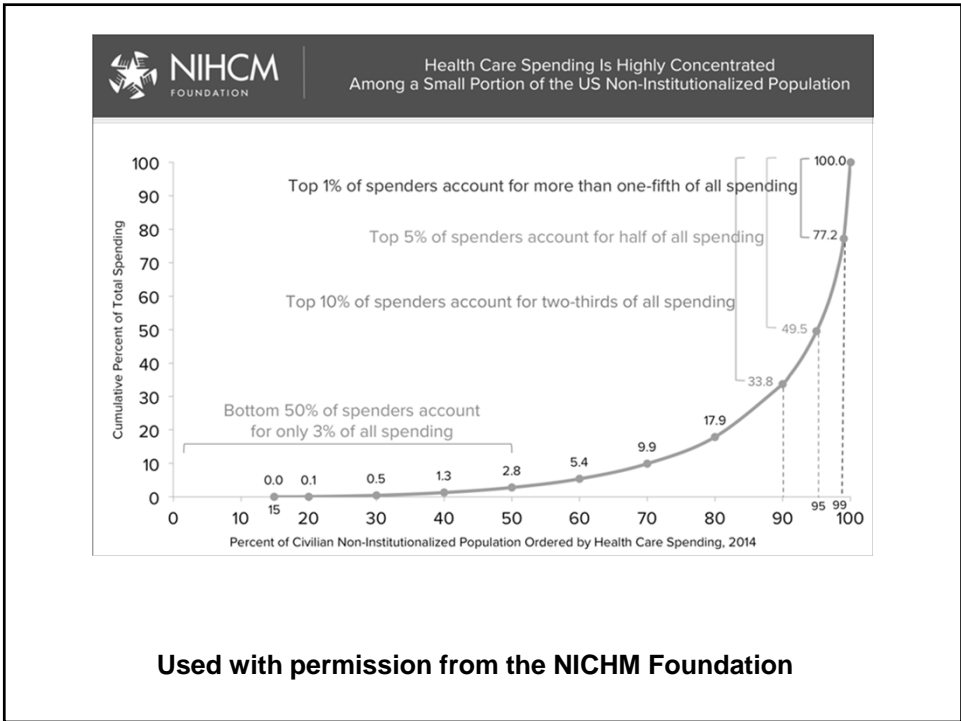
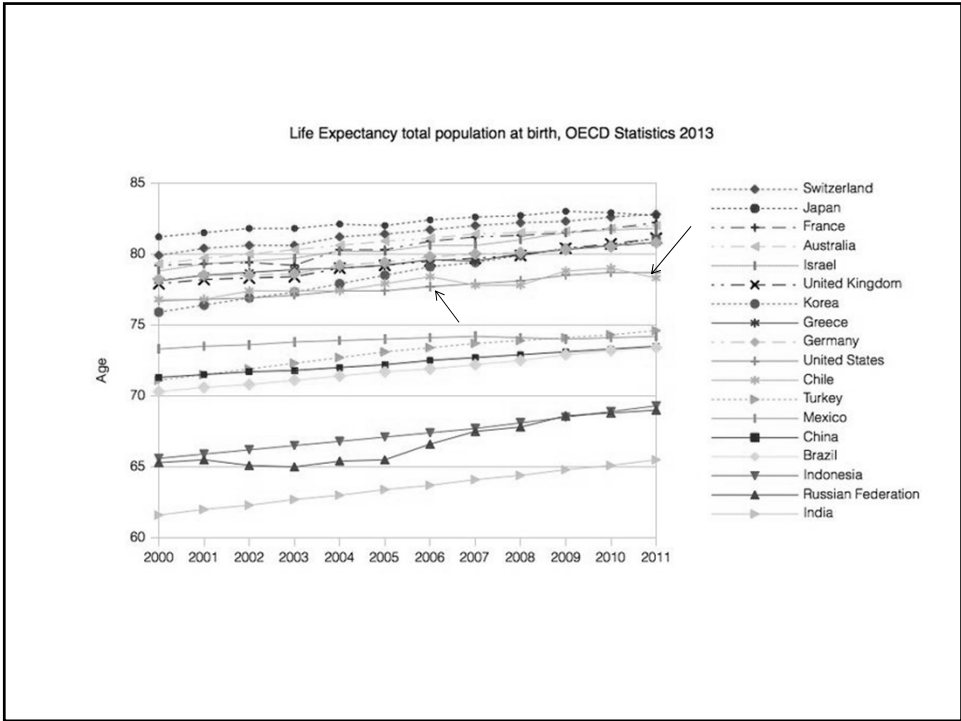
Source: U.S. Centers for Medicare & Medicaid Services

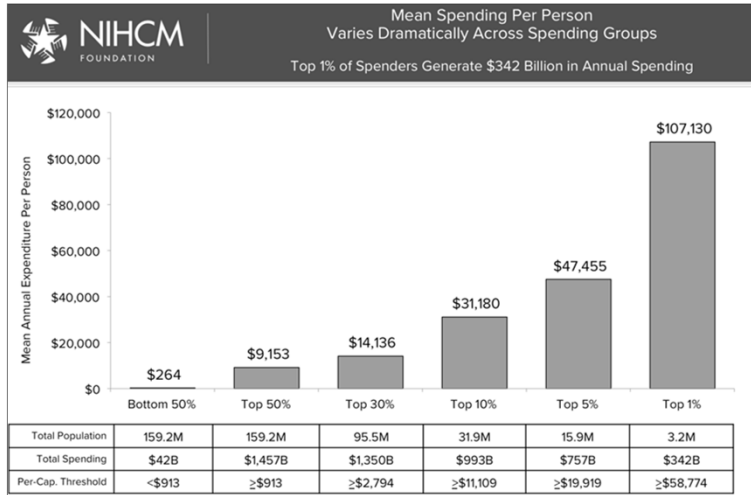
Health Care Spending As A Percent of GDP



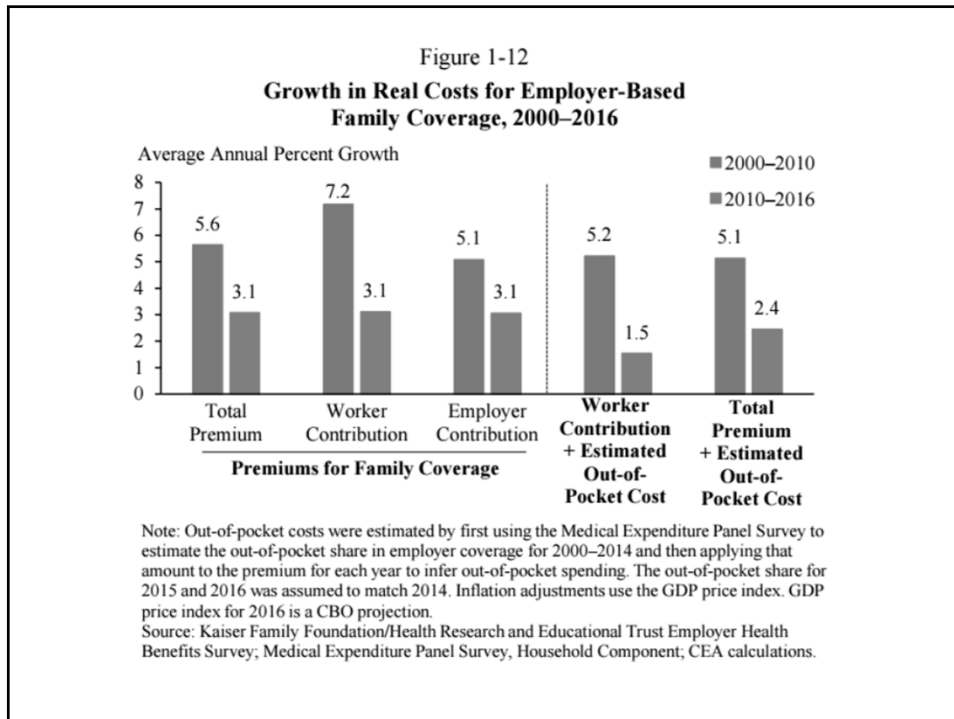
Health Care Financing Review, Centers for Medicare and Medicaid Services





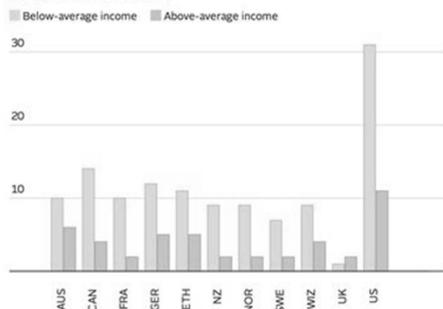


Used with permission from the NICHM Foundation



America's health care system is the least equal

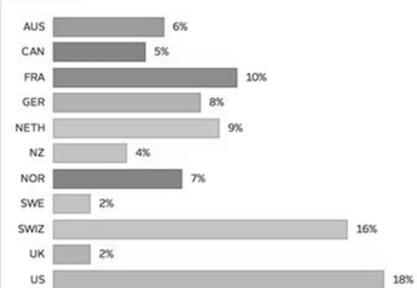
Percent of patients who "did not get recommended test, treatment, or follow-up because of cost in the past year."



Source: The Commonwealth Fund

America has the least efficient health care system

Percent of patients who reported spending "a lot of time on paperwork or disputes related to medical bills"



Source: The Commonwealth Fund

Private Sector Costs

- **General Motors: In 2007, cost of healthcare exceeds the cost of steel per car**
- **Starbucks: In 2005, cost of healthcare exceeds cost per coffee in each cup**

Private Sector Costs

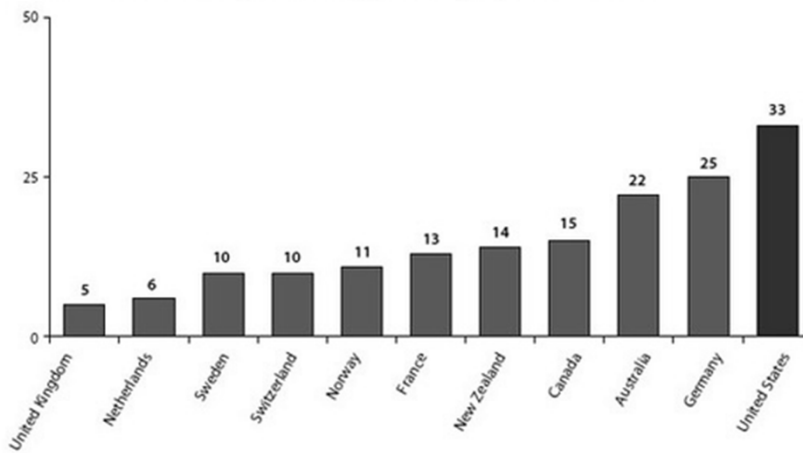
- **American businesses are losing their ability to compete in the global marketplace.**
- **Health care at General Motors puts the company at a \$5 billion disadvantage compared to Toyota**

The Cost of one test

- **1 extra test per day = 253 tests per year.**
- **\$100 per test x 253 = \$25,300 per year for ONE PHYSICIAN.**
- **There are 661,400 (Bureau of Labor Statistics, 2008) physicians in the US.**
- **661,400 ordering 1 extra \$100 test per day costs - \$16,733,420,000 per year**

Access Problems Because of Costs, 2010

Percent of adults who had any of three access problems* in past year because of costs



*Did not get medical care because of cost of doctor's visit; skipped medical test, treatment, or follow-up because of cost; or did not fill Rx or skipped doses because of cost.
Data: 2010 Commonwealth Fund International Health Policy Survey.

Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2011.

Accountable Care Organizations

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Bottom Line:

- **Current health care costs are not sustainable**
- **Health Care Reform:**
 - On 3/23/10, President Obama signed into law the Affordable Care Act
 - **Key Components:**
 - **Volume Versus Value Based Care**
 - **Accountable Care Organizations**
 - **Shared Savings**
 - **Patient Centered Medical Homes**

The Affordable Care Act Becomes Law. HealthCare.gov Website.
<http://www.healthcare.gov/law/timeline/index.html> (Accessed 8-2-17)

Volume versus Value Based Care

- **Primary Care Payment currently depends on *Volume Based Care***
 - **Number of face to face visits**
 - **Traditional fee-for-service model**
 - **Meet productivity standards to maintain salary**
 - **“Hamster-Wheel”**
- ***Value Based Care* is required for health care reform to succeed**
 - **Incentive payments for quality reporting and performance, efficiency, and eventually value**
 - **Value = delivery of good outcomes to patients at low cost (*Encourages better health at lower cost*)**

http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/VBPRoadmap_OEA_1-16_508.pdf
(Accessed 8-2-17)

Healthcare is transitioning towards Population Health Management

Traditional Patient Care vs. Population Health

Focus on:

- Treatment of specific diseases and conditions
- Downstream symptoms of health programs
- Medical and biological determinants of sickness
- Patients
- Healthcare providers, purchasers and health plans
- Typically characterized by payment for volume

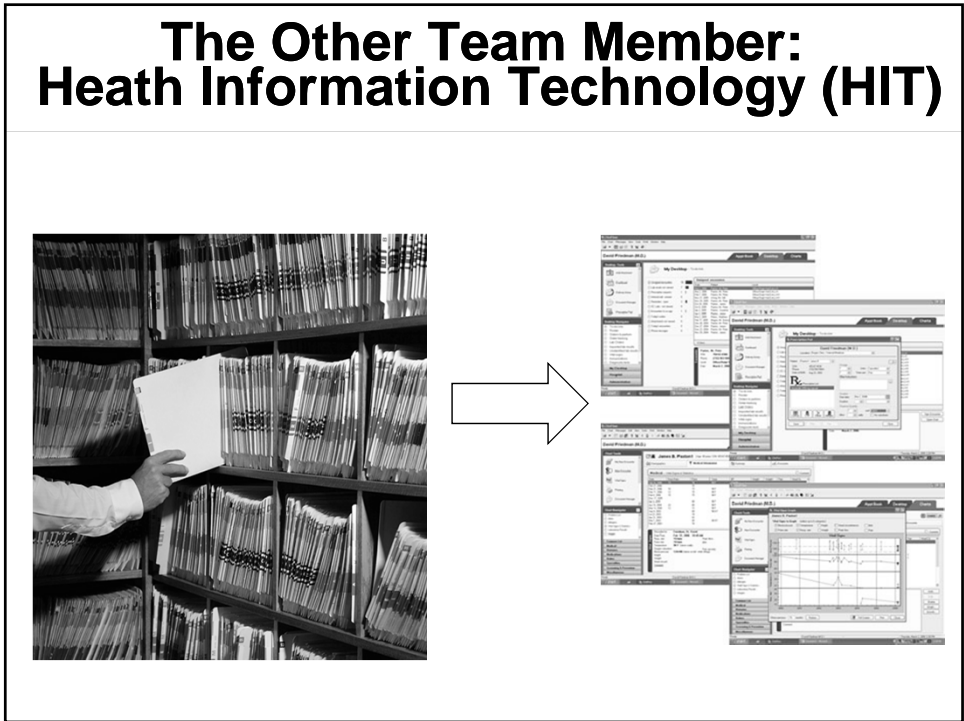
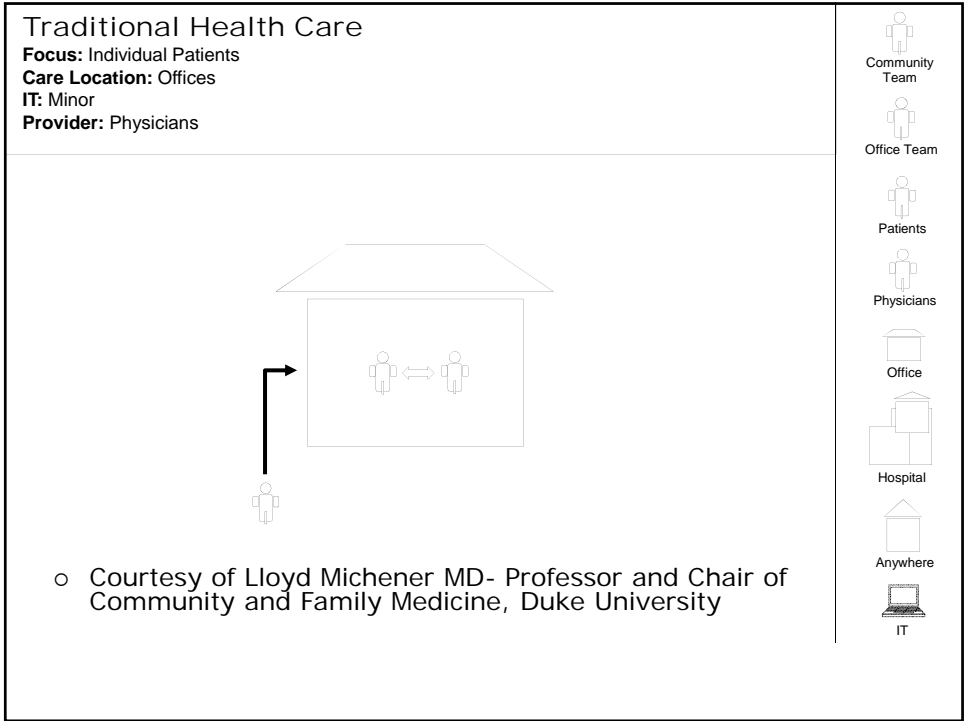
Focus on:

- Wellness, prevention and health promotion
- Upstream causes of health problems and downstream symptom management
- Social determinants of health and community conditions
- All people or population segments
- Partnerships between health entutues and sections such as education, transportation and housing
- Typically characterized by payment for value i.e. higher quality at lower cost

Source: Health Policy Institute of Ohio,
What is population health?

Transformation into Patient Centered Medical Homes

1. Access During Office Hours.
2. Use Data for Population Management
3. Care Management
4. Support Self-Care Process
5. Referral Tracking and Follow-Up
6. Implement Continuous Quality Improvement



HIT – Health Information Technology

- **Electronic Medical Record**
- **Allows for communication between primary team**
- **Allows for coordination between primary team, specialists, hospital, home health**
- **Allows for communication between patient and primary team (Electronic Patient Portal)**
- **Allows for better monitoring of medications and parameters of care for chronic diseases**
- **E-Prescribing**

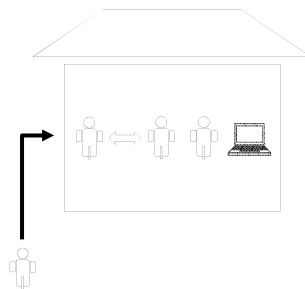
Medical Home Version 1

Focus: Improved outcomes for patients seen in office

Care Location: Offices and hospitals

IT: Minimal

Provider: Physicians and Office team



- Courtesy of Lloyd Michener MD- Professor and Chair of Community and Family Medicine, Duke University

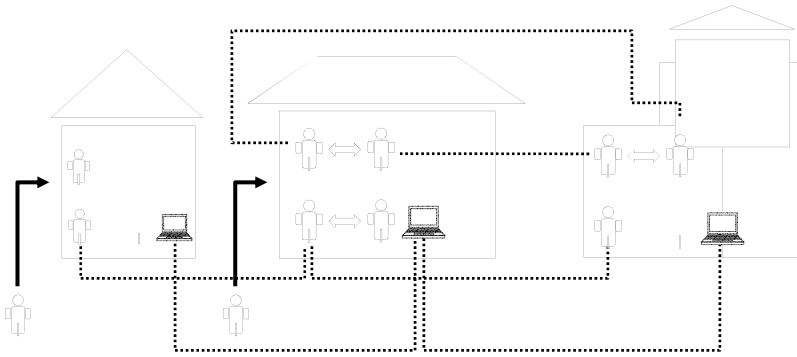
Medical Home Version 2

Focus: Improved outcomes for patients seen across the spectrum of care

Care Location: Offices and hospitals

IT: Somewhat integrated

Provider: Physicians, Office team, and Community team



-  Community Team
-  Office Team
-  Patients
-  Physicians
-  Office
-  Hospital
-  Anywhere
-  IT

- o Courtesy of Lloyd Michener MD- Professor and Chair of Community and Family Medicine, Duke University

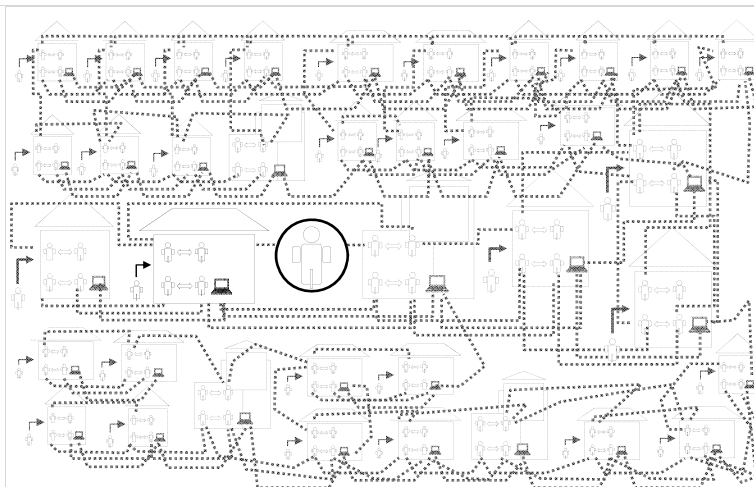
Medical Home Version 3

Focus: Improved outcomes for all

Care Location: Anywhere

IT: Highly integrated

Provider: Network



-  Community Team
-  Office Team
-  Patients
-  Physicians
-  Office
-  Hospital
-  Anywhere
-  IT

- o Courtesy of Lloyd Michener MD- Professor and Chair of Community and Family Medicine, Duke University

PCMH is the Foundation of an ACO

Jacqueline Delmont, MD, is Beacon Health Partners' medical director and is leading the organization's charge toward PCMHs. She says that PCMHs work very well with and under an ACO model. "A patient-centered medical home tries to achieve at the physician practice level the same goals that an ACO is pursuing as an organization," she says. "Even if an organization isn't seeking certification [as a PCMH], the principles of patient-centered medical homes need to be adopted in order for the ACO model to be successful, increasing patient access and satisfaction, improving the quality of care delivered and decreasing healthcare costs."

ACO and Patient-Centered Medical Homes: How One Organization Is Diving Into Both Models. Heather Punke. Becker's Hospital Review | September 27, 2012 | <http://www.beckershospitalreview.com/hospital-physician-relationships/aco-and-patient-centered-medical-homes-how-one-organization-is-diving-into-both-models.html>

What is an Accountable Care Organization (ACO)?

The Medicare Shared Savings Program (MSSP) was established by the Affordable Care Act. An ACO is the mechanism to participate in this program

ACO refers to a legal entity composed of a group of providers that assume responsibility (are accountable) to manage and coordinate care for a defined group of patients in an effective (high quality) and efficient (low cost) manner.

ACO Facts (Medicare Model)

- It is a legal entity
- Comprised of hospitals, PCPs, specialty physicians, allied health providers, radiology, laboratory services
- Requires 5,000 Medicare beneficiaries
- Reimbursement based in Shared Savings Model⁽¹²⁾
 - Members of ACO will share any savings realized with CMS
 - If an ACO saves Medicare money, then a portion of the saved dollars goes back to the ACO and its providers

Who can be an ACO?

- ACO professionals (i.e., physicians and certain non-physician practitioners) group practice arrangements;
- Networks of individual practices of ACO professionals;
- Partnerships or joint ventures arrangements between hospitals and ACO professionals;
- Hospitals employing ACO professionals;
- Certain critical access hospitals;
- Federally qualified health centers, and;
- Rural health clinics.

What are the Benefits of ACOs?

- **Manages patient across all spectrums of care – inpatient, outpatient, and ancillary**
- **Belief that change in health care delivery will lead to: (12)**
 - **Better care for individuals**
 - **Better health for populations**
 - **Lower expenditures for Medicare**

Accountable Care Organizations

- **An ACO is an integrated health care delivery structure comprised of various providers (primary care, specialty care, hospitals, ancillary providers, sub-acute nursing facilities, and others) that are accountable for the cost and quality of the care they deliver.**

Devers K, Berenson R. Can accountable care organizations improve the value of health care by solving the cost and quality quandaries? Robert Wood Johnson Urban Institute. October 2009.

How Care is Measured

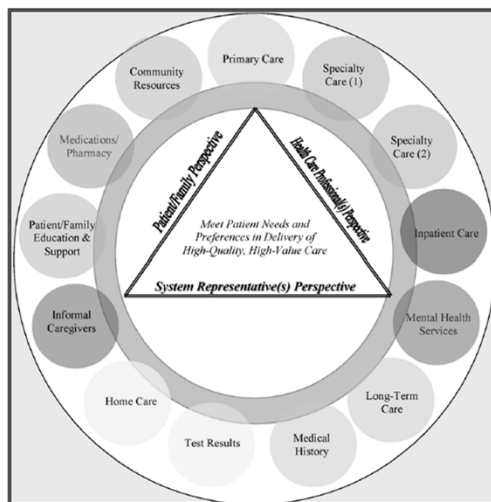
Table 1. Measures for Use in Establishing Quality Performance Standards that ACOs Must Meet for Shared Savings (cont.)

Domain	AIM	ACO Measure #	Measure Title	New Measure	NQF #/ Measure Steward	Method of Data Submission	Phase In PY1	Phase In PY2	Phase In PY3
Patient/ Caregiver Experience	Better Care for Individuals	ACO – 34	CAHPS: Stewardship of Patient Resources	No	NQF #N/A CMS/AHRQ	Survey	R	P	P
Care Coordination/ Safety	Better Care for Individuals	ACO – 8	Risk-Standardized, All Condition Readmission	No	Adapted NQF #1789 CMS	Claims	R	R	P
Care Coordination/ Safety	Better Care for Individuals	ACO – 35	Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM)	No	Adapted NQF #2510 CMS	Claims	R	R	P
Care Coordination/ Safety	Better Care for Individuals	ACO – 36	All-Cause Unplanned Admissions for Patients with Diabetes	No	NQF #TBD CMS	Claims	R	R	P
Care Coordination/ Safety	Better Care for Individuals	ACO – 37	All-Cause Unplanned Admissions for Patients with Heart Failure	No	NQF #TBD CMS	Claims	R	R	P
Care Coordination/ Safety	Better Care for Individuals	ACO – 38	All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions	No	NQF #TBD CMS	Claims	R	R	P

Source: Centers for Medicare & Medicaid Services

Care Coordination

Figure 1. Care Coordination Ring



Source: Agency for Healthcare Research and Quality

ACO Elements of Success

- AAFP has suggested 8 essential elements of an ACO



Figure 1. The Eight Essential Elements of a Successful ACO. Smith, Anderson, Blount, Dorsett, Mitchell & Jernigan, L.L.P. 2011. The ACO Guide: How to Identify and Implement the Essential Elements for Accountable Care Organization Success.

Source: North Carolina Academy of Family Physicians, Inc.

Essential Elements

- **A Culture of Teamwork** –Success of any ACO relies on moving away from “silos” of care
- **Primary Care** – ACO’s are focused on the whole patient. This includes prevention, chronic disease management, care coordination, and improved transitions across care.
- **Health Information Technology and Data** – To adequately manage risk, focus on population health and provide timely and appropriate care, it is necessary to have access to EMR

Essential Elements

- **Patient Engagement – ACOs are patient centered, and require patients to be active and understand their care**
- **Scale-Sufficient Patient Population – Requires patient population**
- **Best Practices Across the Continuum of Care – Improved care coordination, reduced emergency department visits, reduced total hospitalizations, reduced re-admissions, and chronic disease management**

Essential Elements

- **Adequate Administrative Capabilities – Provide adequate administrative support**
 - **performance analysis**
 - **financial management**
 - **clinical care**
- **Adequate Financial Incentives – Appropriate financial incentives are part of success**

Accountable Care Organizations

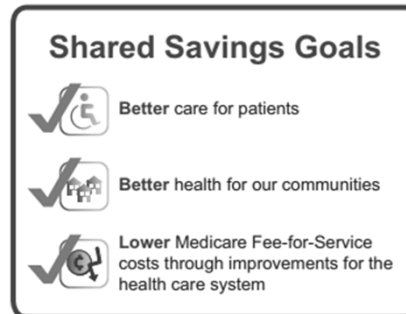
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Payment: CMS Medicare Models

- **Medicare Shared Savings Program-** program that helps a Medicare fee-for-service program providers become an ACO. Apply Now.
- **Advance Payment Model-** supplementary incentive program for selected participants in the Shared Savings Program.
- **Pioneer ACO** -program designed for early adopters of coordinated care. No longer accepting applications.

Shared Savings Program

- **CMS Definition: The Shared Savings Program ACOs are groups of doctors and other health care providers who voluntarily work together with Medicare to give high quality service to Medicare Fee-for-Service beneficiaries. An ACO is not a Medicare Advantage plan or an HMO.**

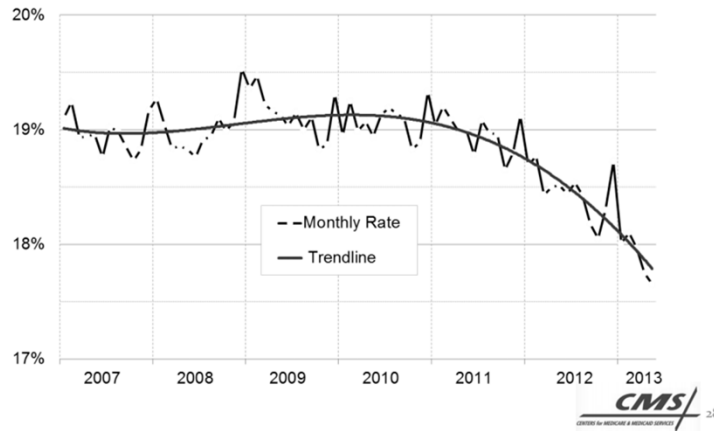


Shared Saving Program (CMS)

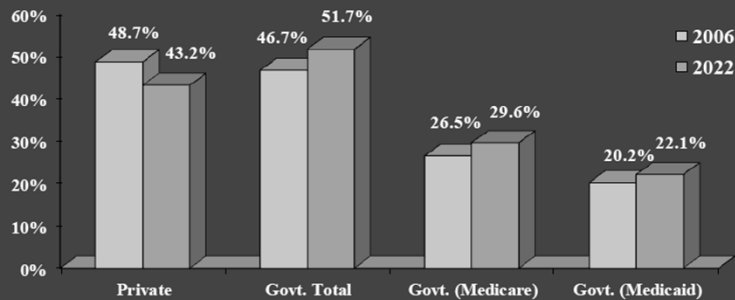
- **Reimbursement based on fee for service PLUS a portion of dollars that Medicare saves due to value based care (decreased hospital readmission, decreased ED visits, preventive health)**
- **Promotes coordination among providers to:**
 - **Improve quality of care**
 - **Reduce unnecessary costs**
- **Designed to:**
 - **Promote accountability (providers, hospitals, suppliers)**
 - **Requires coordination of services**
 - **Encourages investment in infrastructure and the redesign of care processes**

Hospital Readmissions Continue to Decline Steeply

Medicare 30-Day, All-Condition Hospital Readmission Rates
January 2007 - May 2013



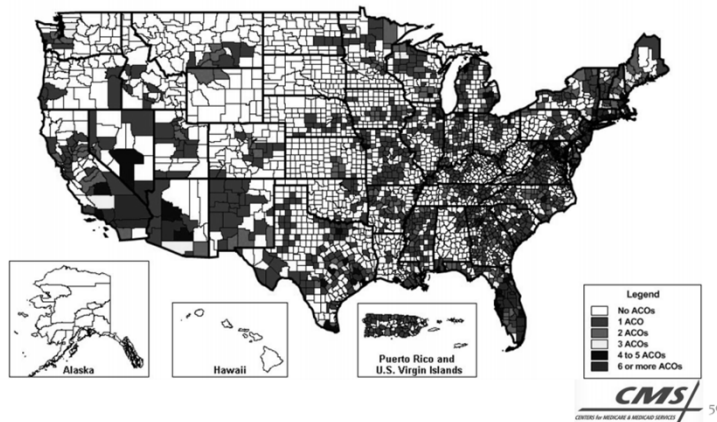
Total Health Insurance Payments by Payer Source 2006 versus 2022 (Percent of Total)



CMS, National Health Expenditure Projections, 2012 to 2022, January 2013.

ACO Participation is Growing Rapidly

- ACO-Assigned Beneficiaries by County
- 360+ ACOs have been established, including 123 new Shared Savings ACOs for 2014
- 5.3 million assigned beneficiaries in 47 states, plus DC and PR



Payment Models

- **Shared Savings-Health System** has a target for expenditures. At the end of the year if they do not exceed that target, they receive a portion of the savings.
- **Bundled Payments**-a single fee is paid for a specific services (such as a heart catheterization) that covers all activity (physician, hospital, pharmacy, lab etc) related to that service. Through innovation if the cost is below that payment, additional revenues are realized.
- **Episodic Payments**-A single fee is paid for a specific service over time. For example, a hip replacement, or asthma care.
- **Global Capitation**-The health system received a PMPM based on number of patients contracted to provide any and all care needed by those patients.

