What is an Accountable Care Organization

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PriMed
THAT'S GONNA BE A HARD PILL TO SWALLOW.

PSSST... IT'S A SUPPOSITORY.
Goals

• Why is U.S. healthcare undergoing dramatic change
• How reimbursement structures are likely to change
• What is the timeline for these changes
• The transition to Accountable Care Organizations
Goal # 1

Why is U.S. Healthcare Undergoing Dramatic Change
Why is Everyone Criticizing U.S. Healthcare?

Premium Price, Poor Performance

The United States spends more on health care per capita—by far—than any of the other OECD countries. Yet it ranks in the bottom 25% of those countries on life expectancy. by Jeff Levin-Scherz
Let’s compare costs of apples to apples

1. OUT-OF-CONTROL PRICING

Health services across the board, from hospital stays to CT scans, cost dramatically more per unit in the U.S. than in other developed countries, where prices are often regulated.

<table>
<thead>
<tr>
<th>ONE DAY IN THE HOSPITAL</th>
<th>A HEAD CT SCAN</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Average price</strong></td>
<td><strong>Average price</strong></td>
</tr>
<tr>
<td>$US</td>
<td>$US</td>
</tr>
<tr>
<td>3,000</td>
<td>1,200</td>
</tr>
<tr>
<td>2,500</td>
<td>1,000</td>
</tr>
<tr>
<td>2,000</td>
<td>800</td>
</tr>
<tr>
<td>1,500</td>
<td>600</td>
</tr>
<tr>
<td>1,000</td>
<td>400</td>
</tr>
<tr>
<td>500</td>
<td>200</td>
</tr>
</tbody>
</table>

**Source:** International Federation of Health Plans, 2009

$950 on average, but can cost twice that.
Does free market competition work in healthcare?

**WHAT TO DO**

**CUT PRICES AND COMPETE**

Though it would be difficult to mandate prices for nongovernmental players, Medicare and Medicaid successfully limit payments, reimbursing far less than other insurers.

**CAPPING PAYMENTS**

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Average Price (US)</th>
<th>Average Price (Medicare)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HEAD CT SCAN</td>
<td>500</td>
<td>500</td>
</tr>
<tr>
<td>HOSPITAL PER DAY</td>
<td>1,500</td>
<td>1,500</td>
</tr>
<tr>
<td>HIP REPLACEMENT</td>
<td>10,000</td>
<td>10,000</td>
</tr>
</tbody>
</table>

**COMPETING ON PRICE**

<table>
<thead>
<tr>
<th>Year</th>
<th>Per-Eye Cost of LASIK Procedures (US)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999</td>
<td>30,000</td>
</tr>
<tr>
<td>2000</td>
<td>25,000</td>
</tr>
<tr>
<td>2001</td>
<td>20,000</td>
</tr>
<tr>
<td>2002</td>
<td>15,000</td>
</tr>
<tr>
<td>2003</td>
<td>10,000</td>
</tr>
<tr>
<td>2004</td>
<td>5,000</td>
</tr>
<tr>
<td>2005</td>
<td>1,000</td>
</tr>
</tbody>
</table>

*Comparison-shopping consumers helped drive down prices.*

Competition among providers and transparent pricing help contain costs. Giving consumers responsibility for spending also lowers easily comparable prices for elective services such as laser eye surgery.
Is Capitation Making a Comeback?

**WHAT TO DO**
**STOP PAYING “BY THE BOLT”**
A study of HMOs found that salaried physicians performed fewer procedures than those paid by fee-for-service.

**PROCEDURE RATES**
Per 1,000 person-years

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Fee-for-Service</th>
<th>Salary</th>
</tr>
</thead>
<tbody>
<tr>
<td>HMO A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ear Tube</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Tonsillectomy</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>HMO B</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ear Tube</td>
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</tr>
<tr>
<td>Tonsillectomy</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

Capitation arrangements, which pay a set rate per patient regardless of services provided, can rein in costs. In one large ophthalmology network, converting from fee-for-service to capitation led to a 51% decline in cataract surgeries in one year.

*Source: Saver et al., Am. J. Manag. Care, 2004*

*Source: Shrank et al., Arch. Ophthalmol., 2005*
How Healthcare Reform Is Different This Time Than 1994?

- There is support from employers and business groups due to soaring costs of covering their employees

- Number of uninsured have ballooned (currently 51 million)

- Medical costs continue to outpace inflation at an unsustainable rate (healthcare costs would surpass 20% of GDP at the current rate)
Healthcare Reform: The Good News

• Number of people insured will increase
  – Subsidies for the poor
  – Insurance mandates
  – Business mandates
Goal # 2

How Reimbursement Structures Are Likely to Change
Healthcare Reform: The Bad News

• The cost of Healthcare Reform will be budget neutral
• Reduction in readmission rates (13% decrease saves $12B)
  – Lower reimbursements
    • CMS eliminates Consultation codes (effective 2010)
  – Increased administrative burden (prior-authorizations, paperwork, etc)
  – Payment based on “best practices” of quality/cost
    - will need to develop infrastructure to track metrics
  – Reduction in premium increases for Medicare advantage plans
How Reimbursement Structures Are Likely to Change

• Bundled Payments / “Accountable Care”
  – Capitation 2.0
  – Fee for service will likely be phased out over the next 5-7 years

• Providers will need to develop financial risk competencies for:
  – Supporting predictive modeling
  – Including utilization management tools
  – Measuring physician performance
  – Monitoring drug utilization
Goal # 3

What is the Timeline for These Changes
2012

- January 1, 2012: Groups of qualifying providers (physician groups, physician hospital joint ventures, hospitals employing physicians) can form ACO’s (Accountable Care Organizations) and share in the cost savings they achieve for the Medicare program
- “One size does not fit all”
  - Success of each model will be market dependant
2013

• Hospitals with higher than expected readmission rates for certain conditions will be penalized with decreased Medicare payments for ALL Medicare discharges

• Medicare will bundle payments to Hospitals, Physicians, post discharge Extended Care Facilities, and Home Health Agencies

• Oct 2013, ICD-9 (13,600 codes) will be changed to ICD-10 (69,000 codes)
2014

• Individual mandates
• Deadline for states to create Health Insurance Exchanges
• Businesses with 50 or greater employees face penalty if they fail to provide insurance
## Changing Paradigms

<table>
<thead>
<tr>
<th>FROM...</th>
<th>TO...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Silo Care Management</td>
<td>Enterprise Care Management</td>
</tr>
<tr>
<td>Episodes of Care</td>
<td>Coordination of Care</td>
</tr>
<tr>
<td>Discharges</td>
<td>Transitions</td>
</tr>
<tr>
<td>Utilization Management</td>
<td>Right Care at the Right Place at the Right Time</td>
</tr>
<tr>
<td>Caring for the Sick</td>
<td>Keeping People Well</td>
</tr>
<tr>
<td>Production (Volume)</td>
<td>Performance (Value)</td>
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Goal # 4

The transition to
Accountable Care Organizations
ACO Definition

• Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare, Medicaid or commercially-insured patients.

• The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time in the most appropriate setting, while avoiding unnecessary or duplicative services, and preventing medical errors.

• When an ACO succeeds both in both delivering high-quality care and spending health care dollars more wisely, it may share in the savings it achieves for the Medicare program, Medicaid program, commercial insurers and self-funded employers.
Medicare Programs for Accountable Care Organizations

- **Medicare Shared Savings Program (MSSP)**—program that helps a Medicare fee-for-service program providers become an ACO. Need >5,000 Medicare beneficiaries in ACO.
  - Track 1 is a 50/50 shared savings with no downside risk
  - Track 2 is a 60/40 shared savings with downside risk potential

- **Advance Payment ACO Initiative**—a supplementary incentive program for selected participants in the Shared Savings Program.

- **Pioneer ACO Model**—a program designed for early adopters of coordinated care. 32 Pioneer ACOs were designated in late 2011.
Medicare Shared Savings Program

The Centers for Medicare & Medicaid Services (CMS) has established a Medicare Shared Savings Program (Shared Savings Program) to facilitate coordination and cooperation among providers to improve the quality of care for Medicare Fee-For-Service (FFS) beneficiaries and reduce unnecessary costs. Eligible providers, hospitals, and suppliers may participate in the Shared Savings Program by creating or participating in an Accountable Care Organization (ACO).

The Shared Savings Program is designed to improve beneficiary outcomes and increase value of care by:

- Promoting accountability for the care of Medicare FFS beneficiaries
- Requiring coordinated care for all services provided under Medicare FFS
- Encouraging investment in infrastructure and redesigned care processes

The Shared Savings Program will reward ACOs that lower their growth in health care costs while meeting performance standards on quality of care and putting patients first. Participation in an ACO is purely voluntary.

- 27 MSSP ACOs awarded for April 1, 2012
- >100 MSSP ACOs to be awarded by June 29 for July 1 start (incl. MPS ACO Physicians)
- MSSP to continue to accept ACO applicants for 2013
Who Can form an ACO in the MSSP

1. ACO professionals in group practice arrangements
2. Networks of individual practices of ACO professionals
3. Partnerships/JV of hospitals and ACO professionals
4. Hospitals employing ACO professionals
5. CAHs that bill under Method II
6. RHCs
7. FQHCs
8. Other ACO participants not identified above
MSSP ACO Quality Measures & Activities

• **Quality Measures:** The final rule adopts 33 individual measures of quality performance that will be used to determine if an ACO qualifies for shared savings. These 33 quality measures span four quality domains:
  1. Patient Experience of Care
  2. Care Coordination/Patient Safety
  3. Preventive Health
  4. At-Risk Population

• **ACO Quality Improvement Process:**
  1. Promote evidence-based medicine
  2. Promote patient engagement
  3. Development quality assessment and reporting mechanism
  4. Coordinate care across care continuum
Medicare Shared Savings
Where Are Potential Savings?

- Identify high risk patients and be proactive in their care coordination
- Identify/manage/report on patients with one/multiple chronic conditions
- Avoidable Emergency Dept. visits
- Avoidable hospital admissions
- Avoidable hospital readmissions
- Avoidable high cost imaging
Medicare FFS Beneficiary Assignment

- Medicare FFS Beneficiaries are assigned to an ACO based on a plurality of primary care services provided by primary care physicians who are ACO Professionals.
- ACO professionals (primary care physicians) must be exclusive to one ACO.
- ACO providers (specialists) & suppliers can provide services to enrollees in multiple ACOs.
Value for Physicians

- Better Alignment with Hospital
- Marketplace Recognition
- Focus on Outcomes
- Incentives Compensate for Additional Work
- Interface with Multiple Payers
Bending the cost curve

• Identify high risk patients
• Identify and manage patients with one or multiple chronic condition
  – Team based care/telehealth
• Avoid unnecessary ER visits
  – Access, access, access!!!
• Avoid unnecessary high cost imaging
• Avoid unnecessary hospital admissions/readmissions
  – Discharge planners/care coordinators
Aetna, Cigna, Blues unveil new ACOs

July 18, 2012 | By Dina Overland

Several health insurers made moves this week to launch accountable care organizations (ACOs), further demonstrating the industry's hope that ACOs can help defray rising costs.

Aetna is collaborating with New Jersey's Hunterdon Medical Center and its 225 affiliated primary care physicians and specialists in an ACO to enhance care coordination and revamp payment models. Aetna is leveraging its health IT capabilities to help identify missed preventative-care opportunities and close gaps in care, NJBIZ reported.

Under the ACO agreement, aetna will reimburse Hunterdon doctors based on their ability to align payment with patient outcomes, including how many members receive preventive care, whether patients improve chronic conditions and reductions in hospital readmission rates.

Meanwhile, Cigna is joining forces with the Palo Alto Medical Foundation to create the payer's first ACO in California. Like its existing ACOs, Cigna will employ a clinical care coordinator to help patients with chronic conditions navigate the health system. Cigna's ACO also will emphasize preventive and primary care while rewarding doctors for achieving certain health outcomes, reported the San Francisco Business Times.
Summary of Key Points

- Culture Evolves Over Time and Takes Effort
- Physician Engagement Requires Physician Involvement
- Technology Plays Important Role
- Evidence-based Management is Key
- The Need for Change – Preparing for the Future
How will ACO’s effect sleep medicine?