

ACCOUNTABLE CARE ORGANIZATIONS – A GAME-CHANGER

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AAIHDS SPRING MANAGED CARE FORUM
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ACOs a game-changer

What the
heck is an
ACO?

Where
ACOs fit

Why ACOs
matter

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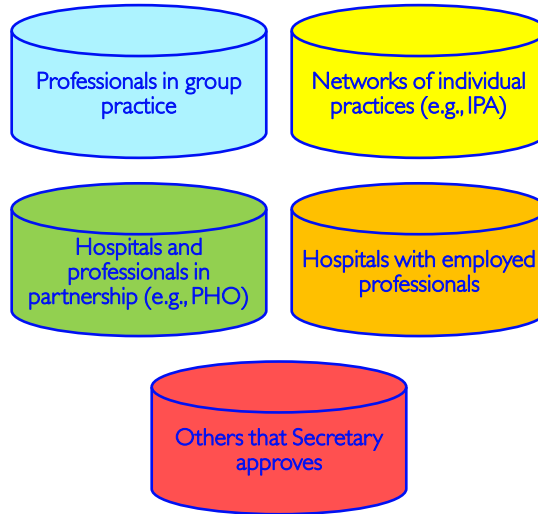
Accountable Care Organizations (ACOs)

- > An ACO is an organization of providers that takes collective responsibility for improving patient care
- > Focus of presentation is on Medicare
- > Three payment approaches
 1. Upside only
 2. Full or Shared Risk
 3. Risk for part of care (e.g., physician services)

ACOs in health reform

- > ACOs to be established Jan. 1, 2012
“Medicare’s Shared Savings Program”
- > Goals
 - o Investment in infrastructure
 - o Redesign care process
 - o Quality and efficiency
- > Medicare Parts A and B
- > Serves traditional Medicare beneficiaries

Who can be an ACO?



Requirements of an ACO

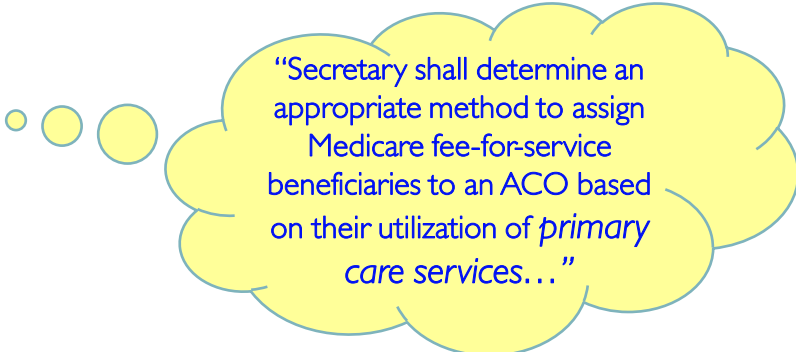
ACO CHECKLIST	
Accountable for quality, cost, and overall care	✓
3-year commitment	✓
Legal structure to distribute payments	✓
PCPs caring for at least 5,000 beneficiaries	✓
Report to Medicare (TBD)	✓
Clinical and administrative systems and leadership	✓
Promote evidence-based medicine, patient engagement, care coordination	✓
"Meets patient-centeredness criteria"	✓
Secretary may prefer ACOs with other contracts	✓

Quality reporting requirements

- > Clinical processes and outcomes
- > Patient experience
- > Utilization
- > Transition of care across healthcare settings
- > Quality measures
- > May alter PQRI (might be excluded from cost calculations)

Secretary to determine exact requirements

Assignment of beneficiaries to ACOs



“Secretary shall determine an appropriate method to assign Medicare fee-for-service beneficiaries to an ACO based on their utilization of *primary care services...*”

- > PCPs must be exclusive to one ACO
- > Specialists can be part of multiple ACOs

Payments and Savings

Providers continue to receive FFS payments

- “Medicare is the best wrap network I know”

Shared savings if:

- Meet quality standards
- Costs (average per capita, adjusted for characteristics) are **X%** below the benchmark
- Benchmark is estimated for each ACO, based on 3 years of data, adjusted

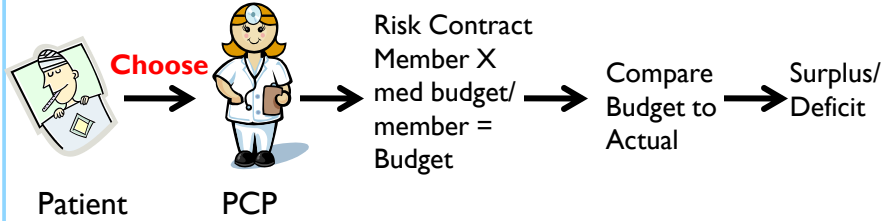
Savings are split by **Y%**, subject to a cap

Three approaches to shared savings

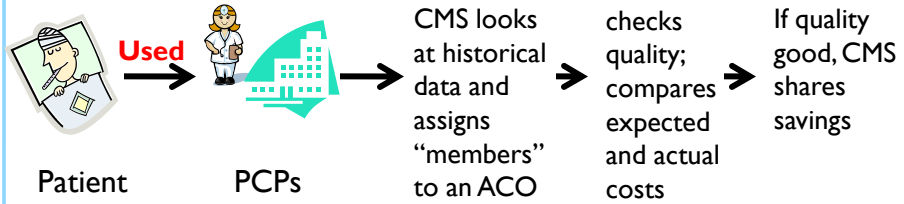
- > Upside only
- > Full or partial risk
 - o Upside and downside
 - o Upside and downside within corridors
- > Risk for part of care (e.g., physician services only)
- > CMS will assess preparedness for particular contracting approach

Financing ACOs

Risk Contract



ACO

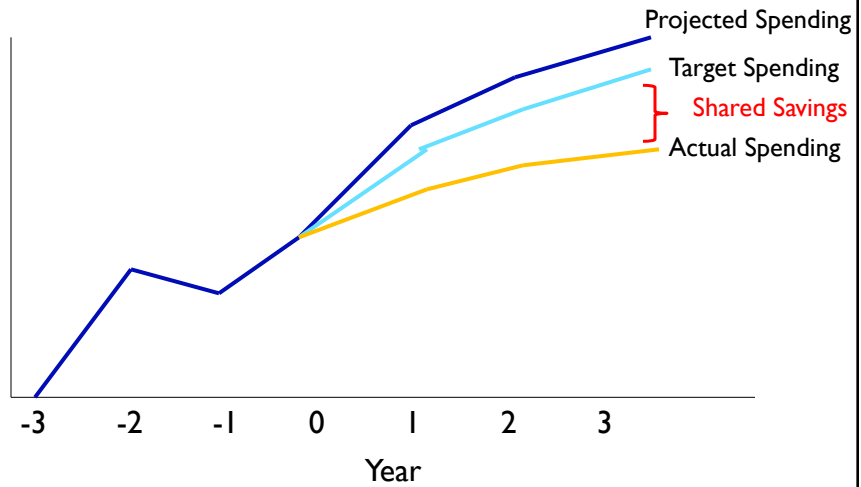


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Upside-only Model



Source: Dartmouth Institute for Health Policy and Clinical Practice

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Costs are tracked across all providers

- > ACOs are loosely managed, no gatekeeper
- > All services are paid at Medicare FFS rates
- > All Part A and B costs are accrued on the ACO's tally

To be determined

- > How to assign "members"
- > Quality requirements
- > Level of reward
 - o Savings required to trigger sharing
 - o Percent shared
- > Size of missed opportunity if not an ACO
- > # of ACOs
- > Will there be limits on how savings can be distributed within the ACO?



What the heck is an ACO?

Where ACOs fit

Why ACOs matter

Before Reform, healthcare was already transforming

- > A push for value and quality
- > Hospital employment of physicians
 - o Employed but often not yet integrated at hospitals
 - > Compensation design is critical
 - > Struggling to engage employed physicians
 - > EHRs may help
 - o Hospital challenge: Living with a mix of employed and independent physicians
 - > Must still engage independent physicians
 - > Some powerful physician groups

Why payment innovations?

- > Broad consensus FFS is not working
 - o Fragmented care, quality concerns
 - o Medicare Part A → bankrupt by 2017
 - o Sustainable Growth Rate formula failed to control costs
- > Recognition that Medicare changes could result in commercial payer changes that may help economy overall

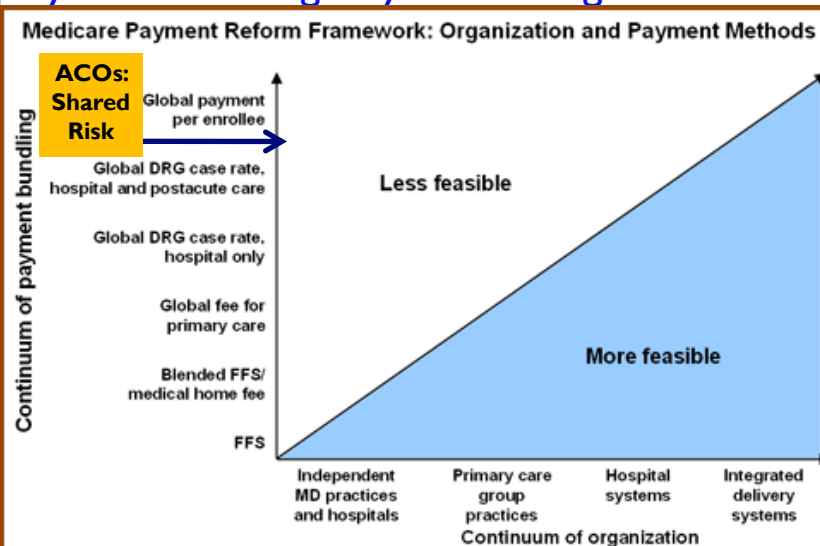
Integrated payment methods may drive integrated system growth

- > Easier to address within one Integrated Delivery System (hospital and physicians)
 - o Challenges still remain regarding aligning incentives
 - o Physicians are critical to successfully managing the overall cost of care
 - o Can address contractually with independent physicians, but it is harder (e.g., PHO)
- > Or physicians may drive it and treat hospitals as vendors, minimizing costs

Berwick will be an “Activist CMS Administrator”

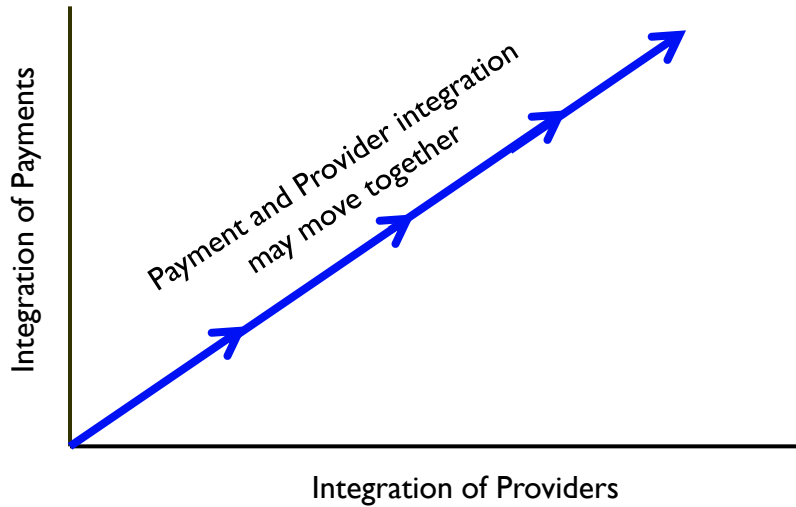
- > Institute for Healthcare Improvement
 - o www.ihl.org
- > “Think out of the building”
- > “The fundamental defect in care is fragmentation”
- > “We need to stop paying for volume.”
- > “Berwick is powerful because of how he thinks.” Atul Gawande

Payment bundling may drive integration



Notes: DRG is diagnosis-related group. FFS is fee-for-service.
 Source: S. Guterman, K. Davis, S. C. Schoenbaum, and A. Shih. “Using Medicare Payment Policy to Transform the Health System: Framework for Improving Performance.” *Health Affairs Web Exclusive* (Jan. 27, 2009):w238–w250.

Future changes in financing and delivery

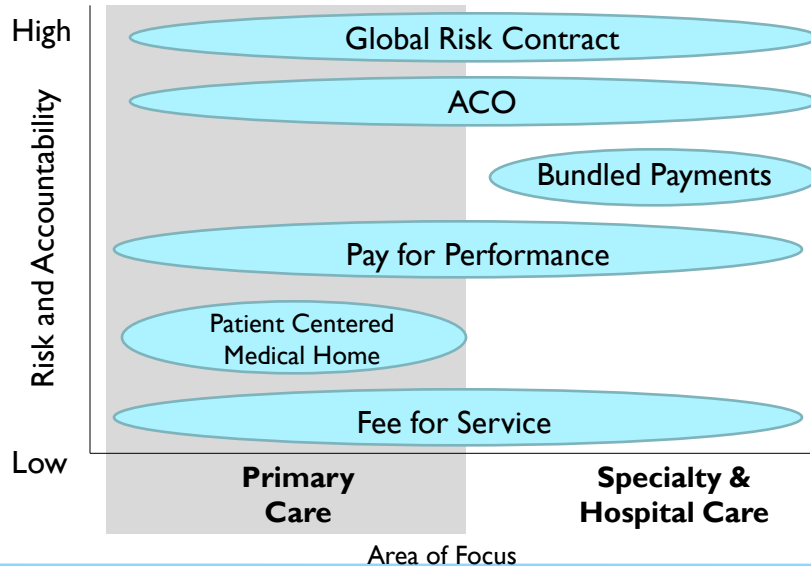


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Risk and focus of major payment innovations

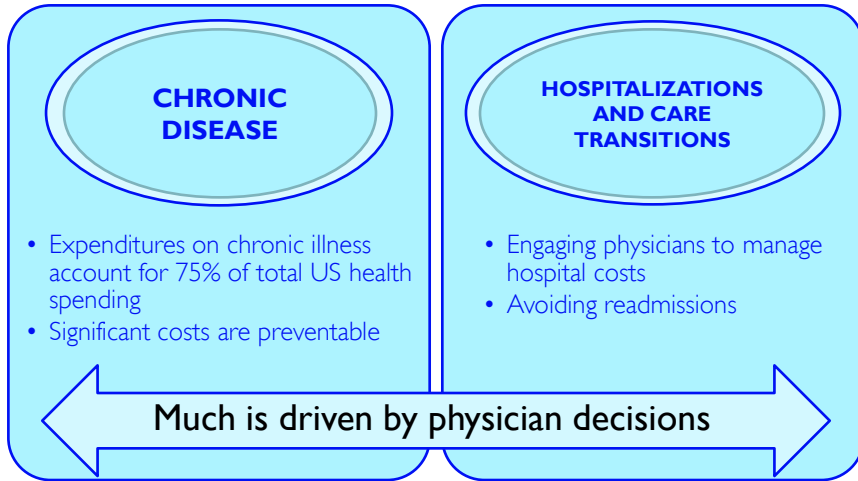


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Because “that’s where the money is”

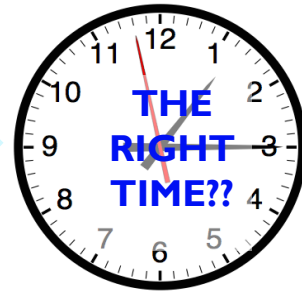
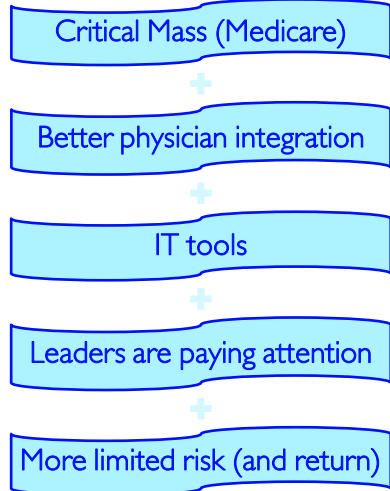


What the heck is an ACO?

Where ACOs fit

Why ACOs Matter

This sounds like a PHO risk contract, Why would it work this time?



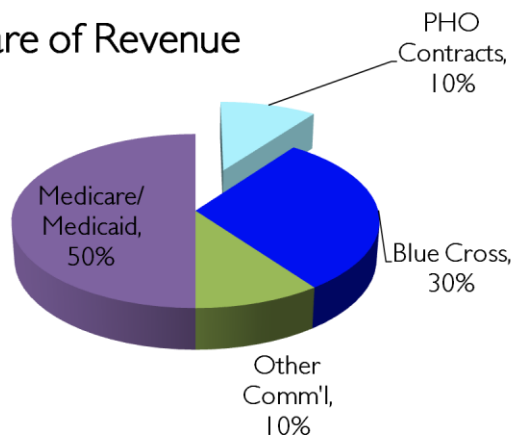
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Typical PHO involvement in local market

Share of Revenue



- > Large payers often bypass PHOs
- > PHO is a small percentage of physician practice and hospital revenue
- > Lack critical mass to drive change

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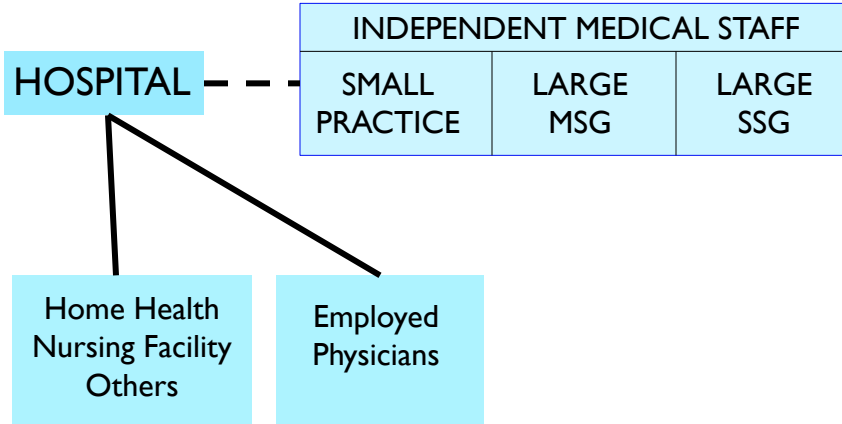
ACO prognosis

- > Could be a major game-changer
- > Still in infancy
- > Assignment of lives may be an issue
- > Risk adjustment must be fair
 - o Coding completeness will be a key to success
- > Could drive providers to integrate more
- > CMS needs to put enough money on the table
- > Will private payers leap into action?

Should we reinvigorate our PHO?

- > The answer is “maybe”
 - o Evaluate capabilities
 - o Consider history and trust
- > Some IPAs or physician groups may become ACOs, squeezing hospitals
- > Some health systems will pursue with employed physicians
- > Are you ready to shift the critical mass?

Typical hospital/health system structure

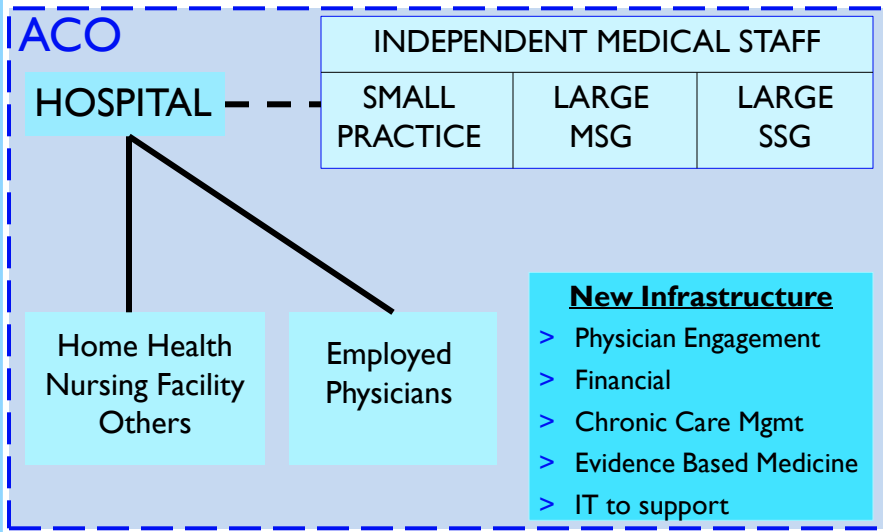


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ACOs need new infrastructure

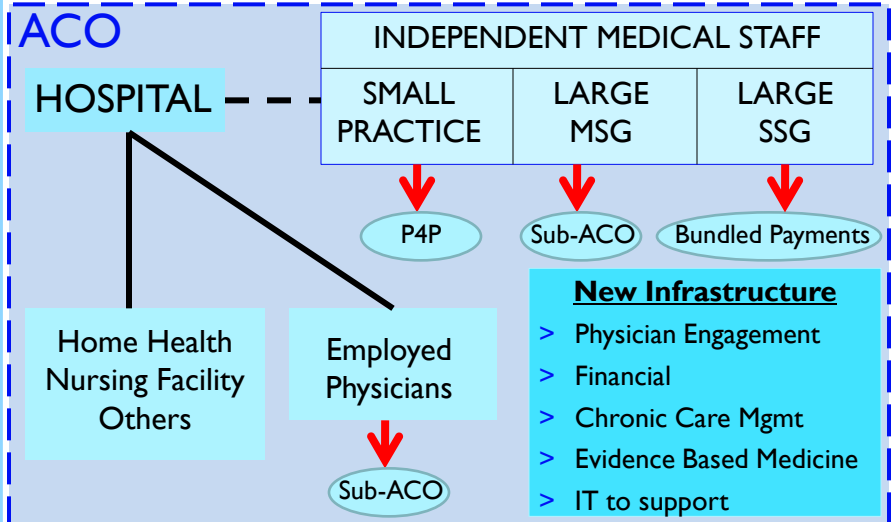


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ACOs may integrate different payment tools



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How big would your ACO be?

Sample Market Area	
Population	630,000
Medicare Beneficiaries	109,000
Medicare Advantage Enrollees	(19,000)
Approximate Enrollees in Traditional Medicare	90,000
Hospital's Share of PCPs	50%
Potential Members for this Hospital's ACO	45,000
Annual Medicare Payments	
Medicare Avg. Annual Payment per Participant	\$11,080
Total Payment for Potential ACO Members	\$500,000,000

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Potential Share of Savings

Potential ACO Share of Savings	
If ACO share of savings is 1%	\$5 million
If ACO share of savings is 2%	\$10 million
If ACO share of savings is 3%	\$15 million

Why bother?

- > Future Medicare payment increases may be in performance-driven bucket
 - o Until Z% of payments to providers are performance-driven
- > Integrated payment methodologies are likely to drive integration of providers
- > ACOs provide critical mass
 - o “You have to want to change”
- > Hospitals may pursue to avoid becoming vendors to physician-driven ACOs

In the end, who will become an ACO?

- > Will hospitals develop ACOs and accept the prospect of driving utilization down?
 - o Shared savings may not make up for lost volume
 - o Can they gain market share to make up for loss?
 - o If they don't do an ACO, will they become vendors to physician-driven ACOs? (Maybe they should)
- > Will physicians see the opportunity to tap funds by squeezing waste from hospitals and specialists
 - o Will they develop the needed infrastructure and guts?

How to succeed

