



Accountable Care Organizations (ACO's) “A new Concept”

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Presentation Outline

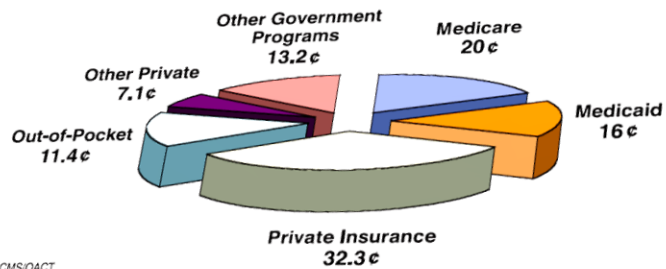
About ACO's

ACO's Proposed Rules

Financial Models

Understanding ACO's Foundation

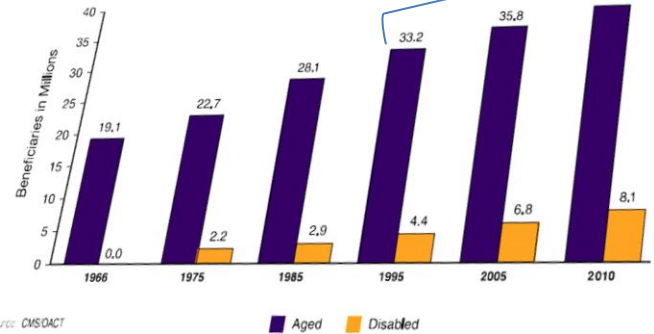
The Nation's Health Care Dollar 2010



Source: CMS/OACT



Medicare Enrollment



Source: CMS/OACT

Total CMS Expenditures as of 2010: \$789.7 Billions

ACO's Background



- ✓ Concept around since 2006
- ✓ Discussed in many reform bills in 2009
- ✓ Finally included in Section 3022 of the Medicare Shared Savings Program of the Patient Protection & Affordable Care Act (ACA) signed into law in March 2010
- ✓ Proposed rules published on March 2011

“The creation of ACOs is one of the first delivery-reform initiatives that will be implemented under the ACA. Its purpose is to foster change in patient care so as to accelerate progress toward a three-part aim: better care for individuals, better health for populations, and slower growth in costs through improvements in care.”¹

Donald M. Berwick
CMS Administrator

SEC. 3022

MEDICARE SHARED SAVINGS PROGRAM

- ✓ Not later than January 1, 2012, the Secretary shall establish a shared savings program that **promotes accountability** for a patient population and **coordinates** items and **services under parts A and B**, and **encourages investment in infrastructure** and **redesigned care processes** for high quality and efficient service delivery
- ✓ Under such program groups of providers of services and suppliers meeting criteria specified by the Secretary may work together to manage and coordinate care for Medicare fee for service beneficiaries through an accountable care organization

What's an ACO?

A legal entity that is recognized and authorized under applicable State law, as defined by an applicable Tax ID number and composed of an eligible group that work together to manage and coordinate care for Medicare FFS beneficiaries and have established a mechanism for share governance that provides all ACO participants with proportionate control over the decision taking process.

In other words, an ACO is a network of MD's & other providers working together to improve quality of health services & reduce costs for a defined population

What's the goal of an ACO?

**To improve quality of health services
&
reduce costs**

Structure of an ACO

- Professionals in group practice arrangements
- Networks of individual practices
- Partnerships or joint venture arrangements between hospitals and individual practices
- Hospitals employing physicians
- Such other groups of providers of services and suppliers as the Secretary determines appropriate

Eligibility Criteria

- The ACO shall be willing to become accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to it
- The ACO shall enter into an agreement with the Secretary to participate in the program for not less than a 3-year.
- The ACO shall have a formal legal structure that would allow the organization to receive and distribute payments for shared savings to participating providers of services and suppliers.
- The ACO shall include primary care professionals that are sufficient for the number of Medicare fee for service beneficiaries
- The ACO shall have at least 5,000 beneficiaries
- The ACO shall have in place a leadership and management structure that includes clinical and administrative systems.

Eligibility Criteria cont.

- The ACO shall define processes to promote evidence based medicine and patient engagement, report on quality and cost measures, and coordinate care, such as through the use of tele-health, remote patient monitoring, and other such enabling technologies.
- The ACO shall demonstrate to the Secretary that it meets patient-centeredness criteria specified by the Secretary, such as the use of patient and caregiver assessments or the use of individualized care plans.

Proposed Rules

Application Process

- A description of how the ACO will partner with community stakeholders
- Participation agreements, employment contracts, operating policies describing rights & obligations in the ACO, share savings that will encourage participants to adhere to the quality assurance and improvement program and evidence-based clinical guidelines
- Documents describing the scope and scale of the quality assurance and clinical integration program
- Supporting materials documenting ACO's organization and management structure
- Board Certified MD as Medical Director

Application Process cont.

- Governing body with at least 75% ACO's participant and control of the body
- Certification by ACO's executive the ACO's participants will be accountable for and to report costs and overall care of beneficiaries
- Indication on how ACO plans to use savings to meet goals of the program
- Description on the criteria to distribute savings among ACO participants and how savings will be use for better care of population and lower growth of expenditures
- Plans describing how to promote evidence-base medicine, beneficiary engagement, report internally on quality and costs metrics, and coordinate care

Application Process cont.

- A description of the individualized care program along with a sample care plan and explanation of how this program is used to promote improved outcomes for at minimum high risk and multiple conditions patients

ACO's Expectations

- An ACO will receive a share of Medicare savings if the ACO is able to meet 2 goals
 - Delivering high quality care
 - Measure by a list of (5 Domains) 65 quality measures based on Hedis, AHRQ and others
 - Benchmark levels will be provided prior to begin and annually thereafter
 - Reducing the cost of care to a level below a benchmark
- Patient Centeredness
 - Must be demonstrated after implementation
 - Beneficiary care survey
 - Beneficiary participation at governance body
 - Process for evaluating health needs of the population assigned
 - Systems to identify high risk individuals
 - Coordination of care mechanism
 - Internal process to measure clinical performance by physicians

Proposed Method for Scoring

- The 65 measures span five quality domains: Patient Experience of Care, Care Coordination, Patient Safety, Preventive Health, and At-Risk Population/Frail Elderly Health
- CMS proposes that the performance on each measure will be scored on a linear points scale and roll up into 5 scores for each of the 5 domain
- The percentage of points earned for each domain will be aggregated using an equal weighting method to arrive at a single percentage that will be applied to the maximum sharing rate for which the ACO is eligible
- The first year of the Shared Savings Program
 - CMS proposes to set the quality performance standard at the reporting level (completely and accurately)
 - CMS proposes to still score quality in the first year for informational purposes and to help define the benchmarks for future program years

Financial Models

- Proposed Track #1
 - Minimizes risks and offer upsides during the learning years
 - Share savings to be reconciled annually for the first two years using 1 sided share savings approach with ACO's not responsible for any portion of the losses above the expenditure target.
 - However for the 3rd year of the agreement, an alternative 2 sided payment model would be imposed(automatic transition)
 - ACO will be required to share losses and savings generated
 - Savings during this year will be reconciled as if they were the first year of the 2 sided model
 - Maximum share saving distribution of 50%
 - Affected by percent attainment of the 5 quality measure domains
 - May not exceed 7.5% of benchmark
 - Minimum savings rate of 3.9 % to 2

Models cont.

- Proposed Track #2 “For more experienced ACO’s”
 - Eligible for higher sharing rates than Track#1
 - Up to 60% of share saving distribution
 - Expenditure target needs to be 2.0%(minimum saving rate or MSR) below the expenditure projection for a group of 5k beneficiaries
 - Affected by percent attainment of the 5 quality measure domains
 - May not exceed 10% of benchmark

ACO's Estimated Developing Cost

- “Medicare estimated that the average cost of developing an ACO would be approximately **\$1,800,000**. In contrast, the American Hospital Association estimated that it would cost a **200-bed, single hospital system** approximately **\$11,600,000** and a **1,200-bed, five hospital system** approximately **\$26,100,000** to develop an ACO.”
- “In response to this criticism, Medicare has proposed three initiatives to get ACO's up and running as soon as possible. The first initiative is the Pioneer ACO Model. Under the **Pioneer Model**, health care delivery systems that already have the providers and systems in place to manage and coordinate care would be permitted to become ACO's and to move from a shared savings model to higher risk/reward models quickly. The second initiative is the **Advanced Payment Initiative**. Under this initiative, Medicare would pay an ACO a portion of its anticipated savings up front in order help the ACO cover its start-up costs. The third initiative is a series of **educational sessions** for those interested in becoming an ACO.”

As seen in the August 5th issue of *The State Journal*

Conclusions

- Development of an ACO will require estimated investment of \$1.1MM to \$5.0MM
- It is uncertain whether this concept will be more successful than HMO's and IPA's from the 90's
- Hospitals/MD's/Insurers need to work as 1 Team to increase opportunities for success
 - Individual competitiveness mind set need to be substitute with an integrated approach