Accountable Care Organizations
Paradigm Shift

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Federal ACOs
Background

- Encourage development of ACOs; a new approach to healthcare aimed at
  1. Better care for individuals
  2. Better health for populations
  3. Lower growth in Medicare Parts A and B expenditures

- Shared Savings Program intent
  1. Promote accountability for a population of Medicare beneficiaries
  2. Improve the coordination of FFS items and services
  3. Encourage investment in infrastructure and redesigned care processes
  4. Incent higher value care
ACO Eligibility Requirements

• An ACO must provide documentation in its application describing plans to:
  – Promote evidence-based medicine
  – Promote beneficiary engagement
  – Report internally on quality and cost metrics
  – Coordinate care
ACO Models

• Two Track Approach for First Agreement Period Only

• Track One or **One Sided Model**
  – Shared savings only option
  – “On-ramp” with less risk
  – Potential of earning 50% shared savings

• Track Two or **Two Sided Model**
  – Shared savings/losses model
  – Performance based risk in exchange for higher reward
  – Potential of earning 60% shared savings

• All ACOs must participate in the two sided model in subsequent agreement periods
Quality Reporting and Performance

• 33 measures selected combining
  – **Process measures**; easier to calculate based on administrative data, such as claims
  – **Outcome measures** including patient experience of care provide a more complete picture of quality of care improvement but rely on both **claims** and **clinical quality** data
  – **Risk adjustment** is included for a number of proposed measures
  – **Of the 33 measures:**
    • 7 are collected via the patient survey,
    • 3 are calculated via claims data,
    • 1 is derived from the EHR Incentive Program, and
    • **22** are collected via the GPRO web interface
## Quality Reporting and Performance

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<td>Total</td>
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ACOs: By the Numbers – CBO Estimates

• Estimated Participation
  – ACOs: 50-270
  – Beneficiaries: 1.0-5.0M

• Costs and Savings (3 years)
  – Total savings: $470M (Federal)
  – Bonuses to ACOs: $1.31B
  – Penalties from ACOs: $20M
  – Average ACO startup cost incl 1st yr operating: $.58M
Federal Programs Today (MSSP)

- April 10, 2012: 27 MSSP ACOs selected
  - The first 27 Shared Savings Program ACOs serve an est. 375,000 beneficiaries, 10,000 physicians, 10 hospitals, 13-smaller physician-driven organizations in 18 States

- July 9, 2012: 150 applications, 89 selected
  - The second 89 ACOs serve an est. 1.2 million beneficiaries in 40 States and Washington, D.C.

- Jan 10, 2013: 106 selected
  - 47 States, PR, and DC are now served
  - Increasing trend toward physician-led practices (approx half of new group)
    - serving <10,000 beneficiaries each; approx 20 percent CHCs, rural health clinics and CAH
Federal Programs Today

• Other Programs
  – Pioneer Model ACOs
    • December 2011: 32 organizations
  – Advanced Payment ACOs
    • January 2013: 35 organizations
  – Physician Group Practice Transition Demonstration
    • January 2012: 6 organizations

• All Told: more than 4 million beneficiaries through 250 organizations in all states except Delaware are receiving care from providers participating in CMS initiatives
Geo Dispersion: Medicare Shared Savings ACOs

Source: Center for Medicare & Medicaid Innovation
4 million Medicare beneficiaries having care coordinated by 220 MSSP and 32 Pioneers ACOs
(Geographic Distribution of ACO Population)

Source: Centers for Medicare & Medicaid
But What is Really Going on?

- Transitions
  - **Pioneer Model ACOs**
    - 32 Original Pioneer ACOs caring for 669,000 Medicare patients and all met the quality criteria. Of those,
      - 18 lowered the average Medicare cost below the benchmark
        » 13 saved enough to share a total of $76M with Medicare
        » 5 with savings not sufficient enough to share with Medicare
      - 14 increased average Medicare costs
        » 5 remain in the Pioneer program
        » 7 switched to MSSP or dropped out
  - **MSSP ACOs**
    - 3 reportedly leaving
Commercial ACOs
ACO Lives and Contracts

Public Programs ~ 5.1 Million

Private Payers ~ 10.6 Million

Top 7 Payers
- Cigna
- Aetna
- UnitedHealthcare
- BCBS of MA
- Anthem
- Blue Shield of CA
- BCBS of MI

265 - Payment Arrangements
- Pioneer: 23
- Medicaid: 26
- SSP: 220

Source: Leavitt Partners Center for Accountable Care Intelligence 2013
Private Sector Activities

ACO implementation accelerating across the country

*Upwards of 250 self-identified ACOs*

The Engelberg Center for Health Care Reform at Brookings | The Dartmouth Institute
Types of ACOs

**Insurer-Led ACO**
- More likely to be a physician group (physician problems)
- Insurer likely to retain formulary decisions

**Multiple-Provider ACO**
- High likelihood of separate governing structures (unless M/A in the works)
- Decisions may be joint but purchases are along original lines (hospital/physician group)

**Single-Provider ACO**
- Tends to be original entity (Billings Clinic, Sharp Healthcare)
- More likely to be looking to develop in-house competency (unless existing)
- Decision making mechanism is less likely to see change*

**Payer-Provider Collaboration**
- Provider partners are diverse
- Payer-involvement varies from
  - TPA/MSO
  - First-payer status (temporary exclusivity)
  - True collaborative partner

Source: Leavitt Partners Center for Accountable Care Intelligence 2013
Geo Dispersion: Commercial ACOs (Top 4)

- Aetna
- UnitedHealthCare
- Cigna
- Anthem

Source: Leavitt Partners Center for Accountable Care Intelligence 2013
Innovation in the Commercial Marketplace

• Commercial Health Plans are engaging with Providers toward Accountable Care. Examples:
  
  – **Aetna**
    
    • Helping to facilitate the clinical, financial, technological and cultural changes required to seamlessly transition to accountable care across all payer relationships
    
    • Aiding in implementing technology to unlock the power of evidence-based medicine and preventive care
      
      – Example of results: 45% reduction in hospital admissions; 50% fewer patient hospital days; $600 annual savings per patient
    
  – **Cigna**
    
    • 66 collaboratives in 26 states covering 700,000 lives
    
    • Strong focus on care coordinators and case managers
ACO SWOT

Goals
• Gain new business/business development/ market competition on care and quality through delivering on The Triple Aim.
• Data stewardship
• Engage our providers and patients to work collaboratively to improve individual and population health management
• Proactive not reactive

Challenges
• How to organize ourselves around cost and service to help mitigate overuse and misuse of services.
• Vertical integration of systems
• Data accuracy
• Clinical and financial implications, including gaining an accurate cost understanding
• Data across systems to support continuity of care
  – Different labs use different standards
  – Vendor databases
• The definition of an ACO is entirely dependent on the product.

Barriers
• Cultural change; behavior change (patients, providers)
• EMR adoption and transitioning
  – Connecting multiple EMRs
  – Interoperability – using multiple EHRs to obtain a standard data set
    • Ex.: moving patient data from one system to another without a single patient identifier
ACO Problem Sets

DATA

• Data standards
• Population management
• Unified Messaging
  • No roadmap for ACOs
• Aggregating, pulling, using meaningful data
  • What’s foundational?
  • What’s ‘nice to haves’?
  • What are legitimate sources of data?
  • Defining quality, reliability of data
ACO Problem Sets

COLLABORATION
Patient and Provider engagement.
Need patients and providers to work together to make ACOs work.
• Incentive Management
  • Incentive for providers to change the way they provide care
  • Incentive for patients/members to change lifestyles
• Accountability Management
  • How to hold providers accountable
  • How to hold patients accountable for their lifestyles
  • How to disperse rewards and penalties
• Change Management
  • Cultural
  • Behavioral (providers and patients)
  • Process improvement
Clinical & Business Intelligence – Turn Data into Action

Hope & promise.... and the challenge

- Data warehousing
- Healthcare data integration
- Enterprise analytics
- Predictive analytics
- Population health
Clinical & Business Intelligence — Analytics Needs

Examples of ACO functions requiring analytics:
- Revenue Cycle
- Clinical Quality & Outcomes
- Physician Performance & Outcomes Analysis
- Patient/Customer Satisfaction
- Chronic Care / Disease Registry / Population Management
- Market (to assess campaign ROI)
- Labor Management
- Physician Performance and Outcomes Analysis
Clinical & Business Intelligence – Tools and Solutions

“Defensive” Risk Management
• Readmissions Management
• Chronic Disease Detection
• Inpatient Length of Stay Management
• At Risk Population Detection
• Hospital Acquired Condition Prevention

“Offensive” Risk Management
• Chronic Care Management
• Tailored Benefit Design
• Wellness Program Management
• Disease Detection & Early Intervention
Take-Aways

• Transitioning healthcare system to fee-for-value is hard
• The accountable care / fee-for-value concept is here to stay
• Technology is both the key and a challenge
• HIMSS is helping
  – Building new resources around the 4 pillars of necessary technology
    • Analytics, Care Coordination, Infrastructure, and Patient Engagement
  – HIMSS14
    • ACO Symposium
      – Transitioning to Fee-For-Value through ACOs, Bundled Payments and Clinical Integration
    • Key Note Speaker: Aetna CEO
HIMSS Resources

- HIMSS Accountable Care page

- HIMSS State HIT Dashboard
  - ACO tracking
    - [http://apps.himss.org/statedashboard/](http://apps.himss.org/statedashboard/)

- HIMSS Analytics
  - Pioneer ACO: Banner Health, C&BI Report (10/12)
  - Pioneer ACO: Atrius Health, C&BI Report (01/13)
    - [http://www.himssanalytics.org/research/](http://www.himssanalytics.org/research/)
Questions?

Thank you!

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