ACCOUNTABLE CARE ORGANIZATIONS

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Summary HCR Implementation Timeline

- Immediate health insurance market reforms
- Increased Medicaid prescription drug rebates
- Medicare Part D “donut hole” relief begins
- Medicare provider rate cuts begin
- Comparative effectiveness institute established
- FDA begins to establish biosimilars pathway

ACOs established

Essential Health Benefits Determined

2010
- Drug manufacturers’ fee begins
- Medicare Advantage payment cuts begin
- Ban on physician ownership of hospitals
- Manufacturers begin to pay 50% of drugs in phased donut hole closure
- GAO 340B report due

2011
- Medicaid expansion
- State exchanges established
- Individual mandate and subsidies
- Employer requirements
- Small business subsidies
- Insurance market reforms fully implemented
- Medicaid 100% federal match to states
- Health insurers’ fee begins
- Medicare/Medicaid DSH payment cuts begin
- Medicare Commission’s first report to Congress

2012
- Increased Medicaid prescription drug rebates
- Medicare Part D “donut hole” relief begins
- Comparative effectiveness institute established
- FDA begins to establish biosimilars pathway

2013
- Coverage expansions take effect
- Essential Health Benefits Determined
- Increase Medicare payroll tax by 0.9% on earned income
- Impose 3.8% tax on investment income
- Eliminate deduction for Medicare Part D subsidy
- FSA limitations
- Excise tax on medical devices
- Medical expense deduction floor increases to 10%

2014
- Medicaid 100% match ends
- 40% excise tax on high-cost health plans

2015
- Medicare Part D donut hole closed
- Medicaid federal match at 90% for subsequent years

2016

2017

2018

2019

2020
So Much Happening…What to Focus On?

- Accountable Care Organizations
- Comparative Effectiveness Research
- State Focus on Health Insurance Exchanges & Medicaid
ACO Basic Architecture

ACO Leadership

Population Health Data Management

Health Home

People

Pharmacy

Specialists

Home Care

Post-Acute Care

Ancillary Providers

Hospitals

Long-Term Care

Hospice

Public Health Agencies

Insurers

CMS

Employers

Payer Partners

Baldzicki
Federally-Sponsored ACOs
...259 to date

Physician Group Practice ACOs
Pioneer ACOs
Apr 2012 MSSP ACOs
July 2012 MSSP ACOs
Jan 2013 MSSP ACOs

6
32
27
88
106

259 to date
## Top 10 ACO Concentrated States

<table>
<thead>
<tr>
<th>State</th>
<th>Number of ACOs</th>
<th>Rank</th>
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<tbody>
<tr>
<td>Florida</td>
<td>31</td>
<td>1</td>
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<tr>
<td>California</td>
<td>24</td>
<td>2</td>
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<tr>
<td>New York</td>
<td>17</td>
<td>3</td>
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<tr>
<td>Massachusetts</td>
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<td>Texas</td>
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<td>Kentucky</td>
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<td>Minnesota</td>
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Definitions of Key Terms

Accountable Care Organization

- Legal entity recognized and authorized under applicable state law, identified by a Taxpayer Identification Number (TIN)
- Comprised of an eligible group of “ACO participants” that work together to manage and coordinate care for Medicare fee-for-service (FFS) beneficiaries
- Only Medicare FFS beneficiaries may be assigned to an ACO; Medicare Advantage enrollees are not eligible
- Established mechanism for shared governance that provides all ACO participants with an appropriate proportionate control over the ACOs’ decision-making process

ACO participant

- Medicare-enrolled provider of services and/or a supplier
Definitions of Key Terms

**ACO provider/supplier**
- Provider of services and/or supplier that bills for items and services it furnishes to Medicare beneficiaries under a Medicare billing number assigned to the TIN of an ACO participant, in accordance with applicable Medicare rules and regulations

**ACO professional**
- Physician (MD or DO) or practitioner (eg, physician assistants, nurse practitioners, clinical nurse specialists)

**Hospital**
- Only acute-care hospitals paid under inpatient prospective payment system (IPPS) may participate in the MSSP
ACA lists groups of providers of services and suppliers eligible to participate in ACOs,* including:

- **ACO professionals** in group practice arrangements
- Networks of **individual practices** of ACO professionals
- **Partnerships or joint venture arrangements** between hospitals and ACO professionals
- **Hospitals** employing ACO professionals
- **Other groups of providers of services and suppliers** as the Secretary determines appropriate
  - CMS determined that **critical access hospitals (CAHs) billing under method II,** federal qualified health centers [FQHCs], and **rural health centers [RHCs]** may form independent ACOs
  - Any other Medicare-enrolled entities can participate in MSSP as ACO participants
ACO requires ACOs to define following processes for patient care**:

1. Promote EBM
2. Promote patient engagement
3. Report on quality and cost measures
4. Coordinate care

ACOs must document how ACO participants and ACO providers/suppliers will—

1) Comply with and implement each process
2) Describe provisions for internal assessment of cost and quality of care that include continuous improvement of care practices
TYPES of ACOs

- Federally-sponsored Medicare ACOs
- Commercial health plan sponsored ACOs
- State-sponsored Medicaid ACOs in or applying to be in Demonstration Programs
- Self-declared ACO-like organizations...
Commercial ACOs are Growing in near tandem with Medicare ACOs

• Some Commercial ACOs were operating in the market several years before Medicare ACOs
• At last count (mid-2012), there were an estimated 162 private ACOs operating in 45 states and the District of Columbia
• Current estimates suggested that there may be double that number operating by the end of 2013
• All major commercial health plans have an ACO strategy
• NCQA has just announced accreditation of six ACOs and may become the standard for Commercial and self-identified ACOs
Medicaid ACOs

- There are currently 7 States operating or applying to be part of Medicaid ACO Demonstration Programs, including:
  - Colorado
  - Utah
  - New Jersey
  - Oklahoma
  - Oregon

- Nearly every State has some sort of ACO enabling legislation on the books
The Goals of federally-sponsored ACOs is the “Triple Aim”:

- better care for individuals
- better health for populations
- lower growth in expenditures

The ACO must become accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to the ACO. Subpart B—Shared Savings Program Eligibility Requirements § 425.100
Eligibility and Governance

**Patient-Centeredness Criteria**

- Measuring clinical/service performance
- Beneficiary experience-of-care survey
- Involvement in governance
- Standards for access and communication
- Evaluating health needs
- Communicating clinical knowledge
- Identify risk and individualized care
- Care coordination

Patient
Defining an Accountable Care Organization (ACO)

- As defined by the Medicare Payment Advisory Commission (MedPAC)
  - Group of primary care providers, specialists and/or hospital and other health professionals who: Manage the full continuum of care and are accountable for the overall costs and quality of care for a defined population.
# Payment Reform Models: Controlling Costs

<table>
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<tr>
<th>Accountable Care Organization (ACO)</th>
<th>Group of primary care providers, specialists and/or hospital and other health professionals who manage the full continuum of care and are accountable for the total costs and quality of care for a defined population.</th>
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<td>Patient Centered Medical Home (PCMH)</td>
<td>A team of providers who care for a patient and improve quality enhanced patient access, while managing costs. Overall coordination of care is led by a primary care physician with the patient serving as the focal point of all medical activity.</td>
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<tr>
<td>Bundled Payments</td>
<td>Bundled payment systems (also known as &quot;case rates&quot; or &quot;episode-based payment&quot;) would make a single payment for all services related to a treatment or condition, possibly spanning multiple providers in multiple settings rather than on a fee-for-service or capitated basis.</td>
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</table>
Baldzicki

Accountable Care Organization: Relationship between Payment Reform Models

• The ACO can be the overarching structure within which other payment reform models can thrive.
  ▪ The **PCMH and Bundled Payments** on their own strengthen primary care and improve care coordination.
  ▪ If adopted within a framework in the ACO model, PCMH and Bundled Payments may add incentives to support not only better quality, but also lower overall spending growth.

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ACOs by Sponsored Entity

The numbers of ACOs sponsored by physician groups have grown by 500% between September of 2011 and 2012.
What does transformation to an ACO model of care look like?

1. The patient is at the center of the care process and integrally involved in the care process decision-making
2. Physicians are truly committed to improving quality of care, keeping patients healthy and reducing costs by using population health methods and best evidence-based practices
3. Significant investment is made into health information and care coordination infrastructure
4. Physician/provider payment systems are at-risk and value-based and incentivize value (quality/outcomes) rather than volume of services
5. Physicians partner with hospitals and other providers to coordinate care across the total continuum of services forming an actual or virtual integrated delivery system
Ultimately, coverage expansion is expected to result in a modified payer mix as 30+ million new insured enter the market.
Implementation of HCR by the States

ACA will extend health insurance coverage to 32 million Americans
- About 16 million of these Americans will receive their coverage through Medicaid programs administered by the states
- The remainder will receive their coverage through state-operated health insurance exchanges

The fundamental changes to Medicaid are to base eligibility on income, without regard to assets, and to set a national eligibility floor for nearly all individuals under age 65
- These changes will expand Medicaid coverage for adults, including parents for whom Medicaid eligibility levels are limited in many states, and adults without dependent children who have been historically barred from Medicaid coverage

Beginning on January 1, 2014, Medicaid will cover nearly all individuals under age 65 up to 133% of the federal poverty level (FPL)
- $14,484 for an individual or $29,725 for a family of 4 in 2011

Individuals and families with incomes above those levels, but below 400% of FPL ($43,560 for individual and $89,400 for family of 4 for 2011), will be eligible for tax credits to help with the costs of insurance premiums for coverage offered through the state-run exchanges
Why are ACOs Important to Manufacturers?

- Providers are exploring ways to work together to ensure that the quality of care they deliver is reflected in whatever evaluative measurements CMS uses.

- Formulary and treatment guideline recommendations will be determined by provider teams with therapeutic and cost-benefit expertise.

- Electronic health records will make the real-world impact of drugs on quality of care and costs more readily available for evaluation, and allow for managing compliance with treatment guidelines.

- Products that can demonstrate improvements in clinical outcomes or reductions in overall healthcare costs will find a more receptive audience in ACOs.

- Companies armed with compelling data will be able to influence the inclusion of their products on formularies and in treatment guidelines.
Implications for ACO and MSSP Stakeholders

- Organizations should be prepared to demonstrate the value (ie, effectiveness and/or safety balanced by cost) of their products
  - ACOs will be developing (or using existing) practice guidelines that may recommend 1 treatment over another
  - ACOs will be scrutinizing the costs and value of every element within the treatment continuum for patients

- ACOs will value and prefer products and treatments that allow patients to be treated in less-expensive settings of care (eg, out of hospitals)

- Access to unique products may not be impacted adversely, as the reimbursement incentives for the MSSP remain the same as traditional Medicare FFS

- To maximize access for their products, organizations should understand ACOs’ 1) medical practice/clinical guidelines, and 2) quality assurance and process-improvement committees, as the ACO hierarchy may require developing new relationships

- The exclusion of Part D expenses from calculating ACOs’ per capita expenditures may lead to ACOs and providers shifting beneficiaries away from utilizing Part B drugs, and towards using equivalent Part D drugs
Example: Brookings-Dartmouth ACO Collaborative

**Principal Goal**
To engage stakeholders in piloting the ACO model and produce a successful and replicable model that can be implemented nationwide.

**Pilot Sites**
In-depth consultation, technical assistance, and data analysis for participating health systems and payers.

**Learning Network**
Offers practical guidance and a forum for interested parties to learn from one another throughout the process of planning and implementation.

**Community Initiatives**
Serve as strategic support for regions interested in piloting this at the community-level.

**Washington Support**
Serve as a resource for legislative and executive staff on delivery system reform, specifically related to the ACO model.

Source: Dartmouth-Brookings ACO pilot project
## Emerging ACO Models - Governance

<table>
<thead>
<tr>
<th>Model</th>
<th>Characteristics</th>
<th>Current Examples</th>
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</table>
| **Integrated delivery systems/networks (IDN)** | • Own hospitals, physician practices, perhaps insurance plan.  
• Aligned financial incentives.  
• E-health records, team-based care. | Geisinger Health System  
Group Health Cooperative of Puget Sound  
Kaiser Permanente  
Summa Health System |
| **Multispecialty group practices (MSGP)** | • Usually own or have strong affiliation with a hospital.  
• Contracts with multiple health plans.  
• History of physician leadership.  
• Mechanisms for coordinated clinical care. | Cleveland Clinic  
Marshfield Clinic  
Billings Clinic  
Virginia Mason Clinic |
| **Physician-hospital organizations (PHO)** | • Nonemployee medical staff.  
• Function like multispecialty group practices.  
• Reorganize care delivery for cost-effectiveness. | Greater Newport Physicians (partners with Hoag)  
St. Vincent Healthcare in Billings  
Methodist LeBonheur Healthcare  
Kettering Health Network |
| **Independent practice associations** | • Independent physician practices that jointly contract with health plans  
• Active in practice redesign, quality improvement. | Atrius Health (eastern Massachusetts)  
Hill Physicians Group (southern California)  
Monarch HealthCare (southern California) |
| **Virtual physician organizations** | • Small, independent physician practices, often in rural areas.  
• Led by individual physicians, local medical foundation, or state Medicaid agency.  
• Structure that provides leadership, infrastructure, resources | Community Care of North Carolina  
Grand Junction (Colorado)  
North Dakota Cooperative Network |

*Source: Article by Stephen M. Shortell and Lawrence P. Casalino*
Health Care Organizations Face Opportunities and Challenges in the Post-reform Era

Convergence of market forces and implementation of HCR will have significant impact on companies; as such, organizations must monitor and be prepared to respond to a myriad of changes to ensure commercialization success.

Opportunities & Challenges

- Development of health insurance exchanges
- Medicaid expansion
- Integrated healthcare systems
- Impact of ACOs and payment-bundling pilots
- Comparative effectiveness research
- Need for new solutions to ensure patient access
- Patient education and navigation support
Additional Resources

Greenway’s Government Affairs Updates
- Accountable Care Strategies (http://tiny.cc/m2nsfw)
- Gov’t Affairs (http://bit.ly/y5XArU)

Important Government & HHS Sites
- CMS Innovation Center (http://www.innovations.cms.gov/)
- HHS Breach Notification Rule (http://tiny.cc/xytg5)
- HHS Privacy Rule (www.hhs.gov/healthprivacy/)

Agency ACO Sites
- Medicare ACO Final Rule (http://tiny.cc/pem0cw)
- CMS Educational Events Page (http://tiny.cc/aszkn)
- CMS ACO/ Shared Savings Page (http://www.cms.gov/sharedsavingsprogram)
Patient Centered Medical Home
What is a Medical Home?

- A medical home is a model of primary care that delivers care that is:
  - Patient-centered
  - Comprehensive
  - Coordinated
  - Accessible
  - Continuously improved through a systems-based approach to quality and safety
Benefits of PCMH

Improvements in:

• Quality of care
• Patient experience and access
• Work environment
• Reimbursement from key payors (in some states if recognized)

Reductions in:

– Costs related to preventable, duplicative and unnecessary care  ER visits/Inpatient stays
Concerns about PCMH

- Providers working together
- Patients perception of restricting access
- Financial considerations, particularly with respect to how reimbursement would be divided among the providers involved in the patient-centered medical home, as well as restrictions in service that might be placed on care by payer organizations.
PCMH and ACOs:

• Patient-centered medical homes would play a very close role with ACOs and be one means for delivering service within the ACO model.
• PCMH’s are a basis for forming a ACO
• PCMH’s allow for the coordination of care across the continuum of care and should be considered as part of an organizations care delivery strategy
• One of the key differences seen between patient-centered medical homes and ACOs was that patient-centered medical homes are seen to be driven by the primary care physician, whereas ACOs are seen as driven from the hospital or health system perspective.
NCQA

- The patient-centered medical home model emphasizes care coordination and communication.

- Currently, nearly 7,700 health care providers at more than 1,500 locations have met NCQA's standards to receive recognition as a patient-centered medical home.