



## Accountable Care Communities 101

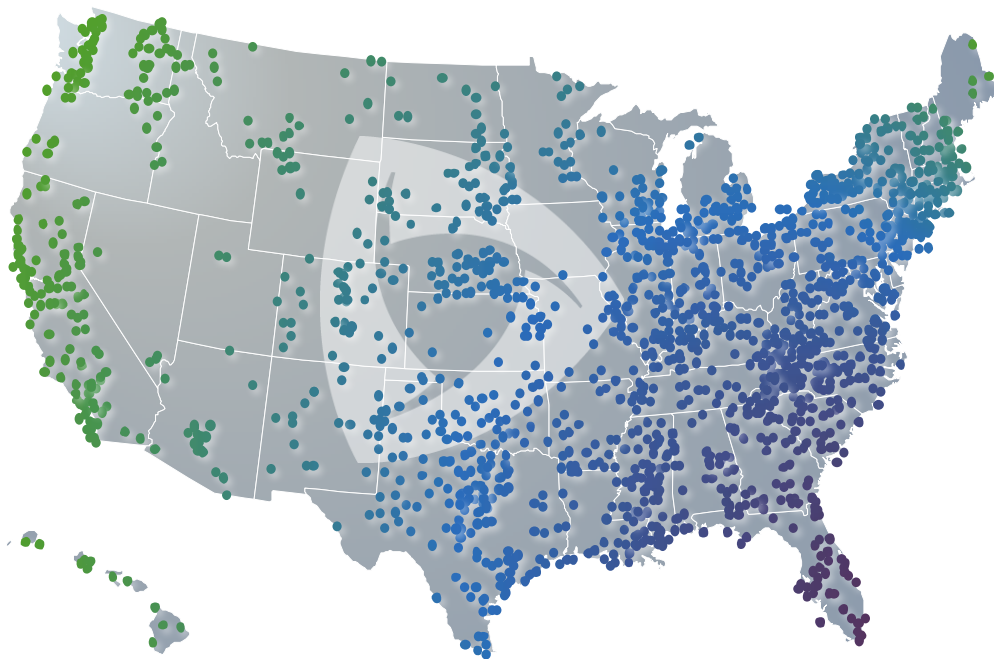
Jennifer M. Flynn, Esq.  
Senior Director, State Affairs  
Premier healthcare alliance

*January 30, 2014*



# ▶ Premier is the largest healthcare alliance in the U.S.

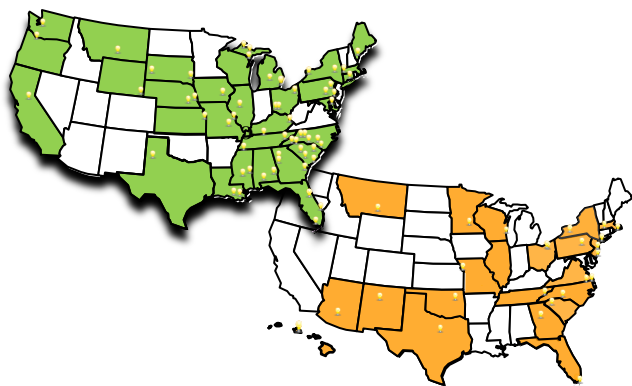
## Our Mission: to improve the health of communities



- ▶ Uniting more than **2,800** hospitals – 40% of all U.S. hospitals – and nearly **93,000** alternate sites of care
- ▶ **\$40+ Billion** in group purchasing volume, **\$5 Billion** in savings in 2012
- ▶ Database representing **1 in every 4** discharges
- ▶ **2.5 Million** clinical real-time transactions each day
- ▶ Named six times as Ethisphere most ethical company
- ▶ Malcom Baldrige Quality Award Winner



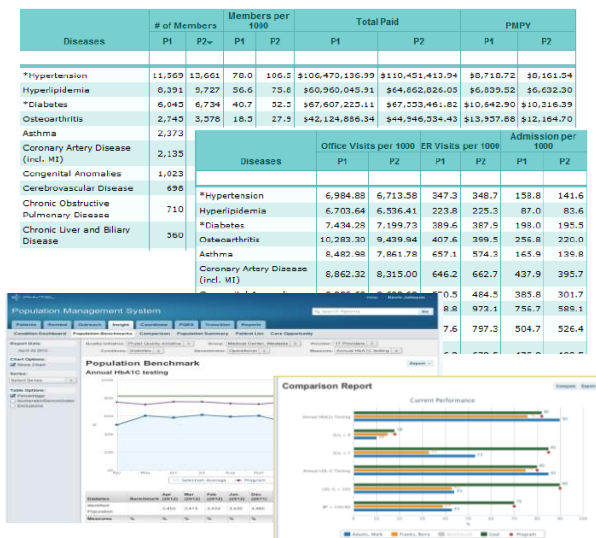
## Connecting People: National ACO Collaboratives



## ACO Implementation & Readiness

80+ members collaborating on best practices  
120+ market assessments

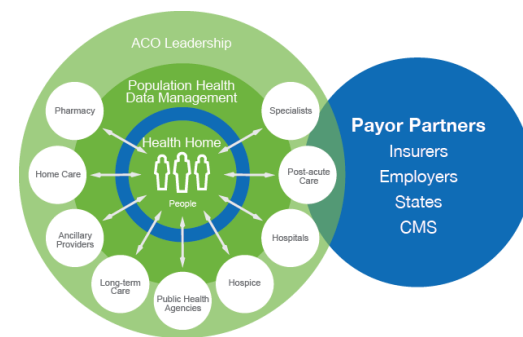
## Connecting Data: Population Health Analytics



## Population Health data management

Analytics supporting clinical integration and risk-based relationships

## Connecting Knowledge: Operational Deployment



## Resources to build capabilities

Cohorts, best practices portal, guidebooks, tools, vendor contracts

# ▶ Today's discussion

---

- ▶ What is an ACO?
  - ACO Model
- ▶ What do ACOs look like?
  - Incentives
    - » Shared Savings
  - Medicare
    - » Basics
  - Medicaid
    - » Colorado
- ▶ ACO's future
  - Growth
  - Results
  - Challenges



# What is an Accountable Care Organization?

---

Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers, who come together to provide coordinated high quality care to their patients.

The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors.

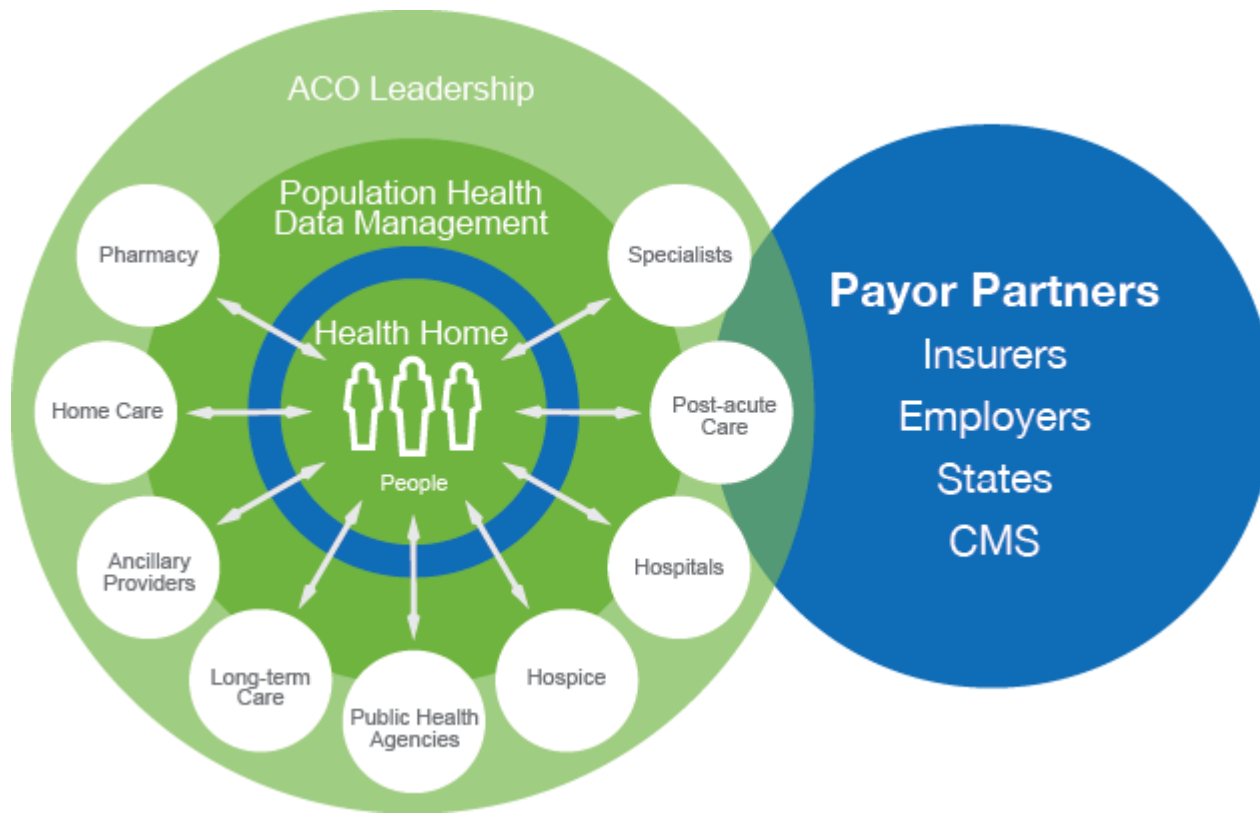
When an ACO succeeds both in both delivering high-quality care and spending health care dollars more wisely, it will share in the savings it achieves.

ACOs were designed with a three-part objective:

1. **Better Care** – in a safe environment, equitable to all who seek it and available when needed
2. **Improved Health** – accomplished through prevention and chronic care management
3. **Lower Per Capita Costs** – intended to reduce the trend of cost increases associated with the Medicare FFS population

# The Accountable Care Organization Model

A group of providers willing and capable of accepting accountability for the total cost and quality of care for a defined population.



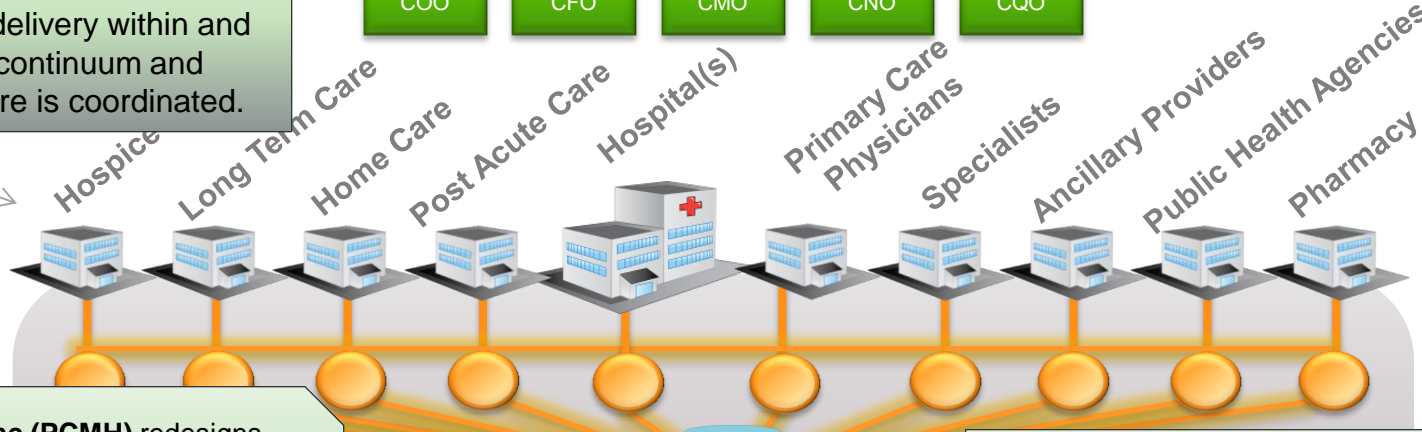
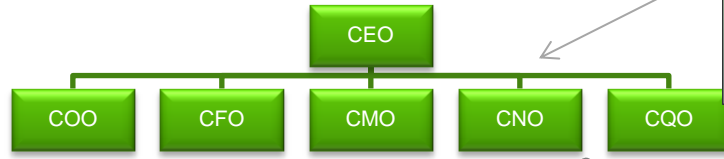
## Core Components:

- People Centered Foundation
- Health Home
- High-Value Network
- Population Health Data Management
- ACO Leadership
- Payor Partnerships

# What does an ACO look like?

**Leadership** addresses the strategic leadership and operational infrastructure necessary to support a successful network that is organized around Triple Aim goals.

**High Value Network** delivers provider networks that will optimize care delivery within and across the continuum and ensure that care is coordinated.



**Medical Home (PCMH)** redesigns primary care to create a new PCP model that provides people centric care as well as care guidance to the practice population, and **Health Home** provides population care management

**Population Health Data Management** facilitates the flow and analysis of clinical, financial, and patient related data and information across all components of accountable care delivery system.

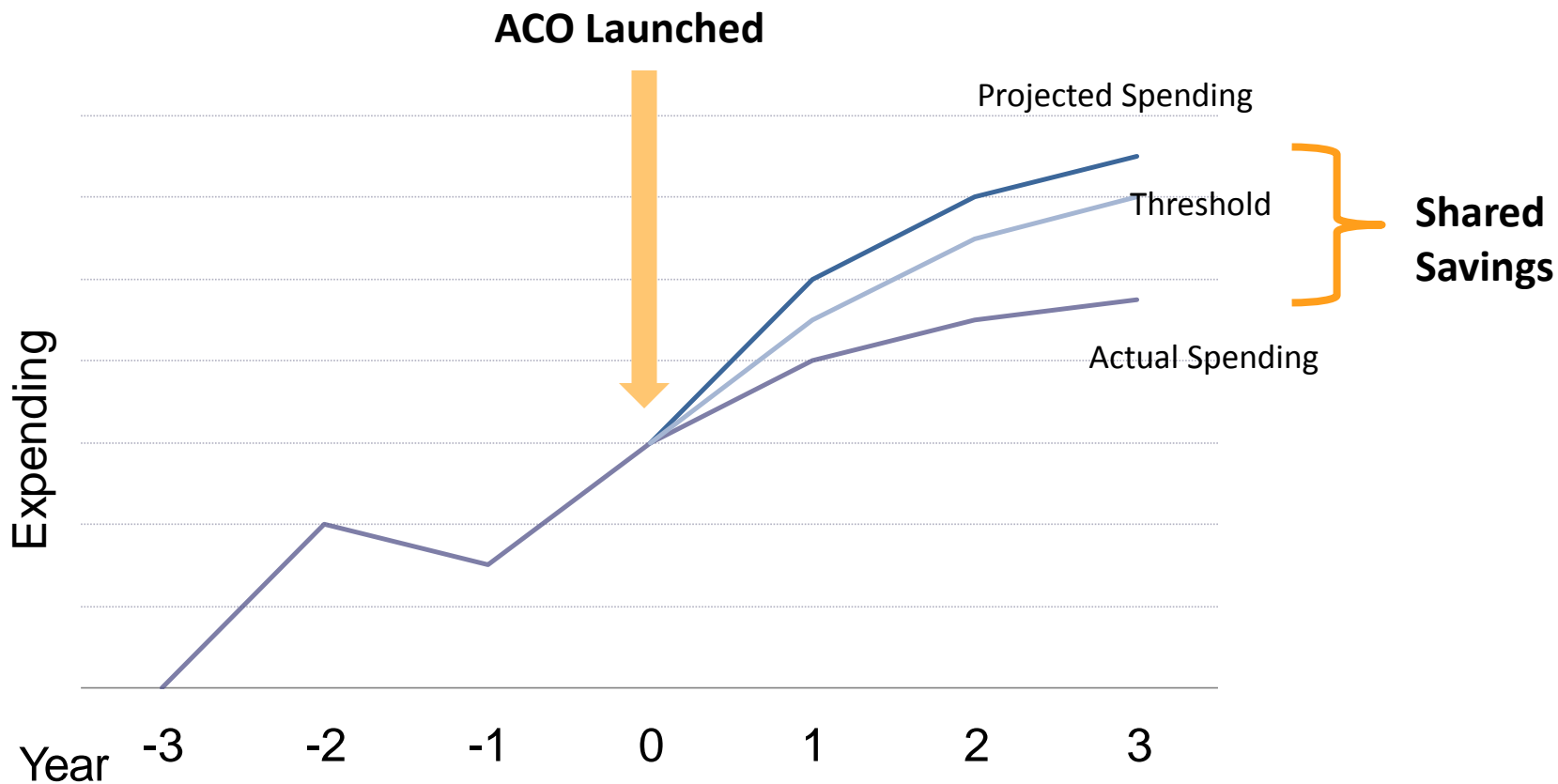
**People Centered Foundation** will ensure that the first principle for accountable care design and ongoing operations is to enable all people within the AC community to meet their needs and desires for good health.

**Payer Partnerships** - focused on the framework necessary for the network to develop and maintain mutually advantageous relationships with AC payer partners (plans and employers).

**Payer Partners**



# Basic Shared Savings Model



Source: Lewis, Julie. "What Could be Next for Health Reform? The Debate In Washington" Presentation. The Dartmouth Institute for Health Policy & Clinical Practice. 2009-07-02.







## Track 1

- One-sided (shared savings only) risk model
- Caps savings at 10% of benchmark
- Threshold of 2%-3.9% depending on size of population
- Once MSR met, share up to 50% of first dollar savings depending on quality scores



## Track 2

- Two-sided risk (shared savings and losses)
- Up to 60% shared savings
- First dollar savings/loss after 2% MSR surpassed
- Caps savings at 15% of benchmark
- Caps losses at 5% in year 1, 7.5% in year 2, and 10% in year 3



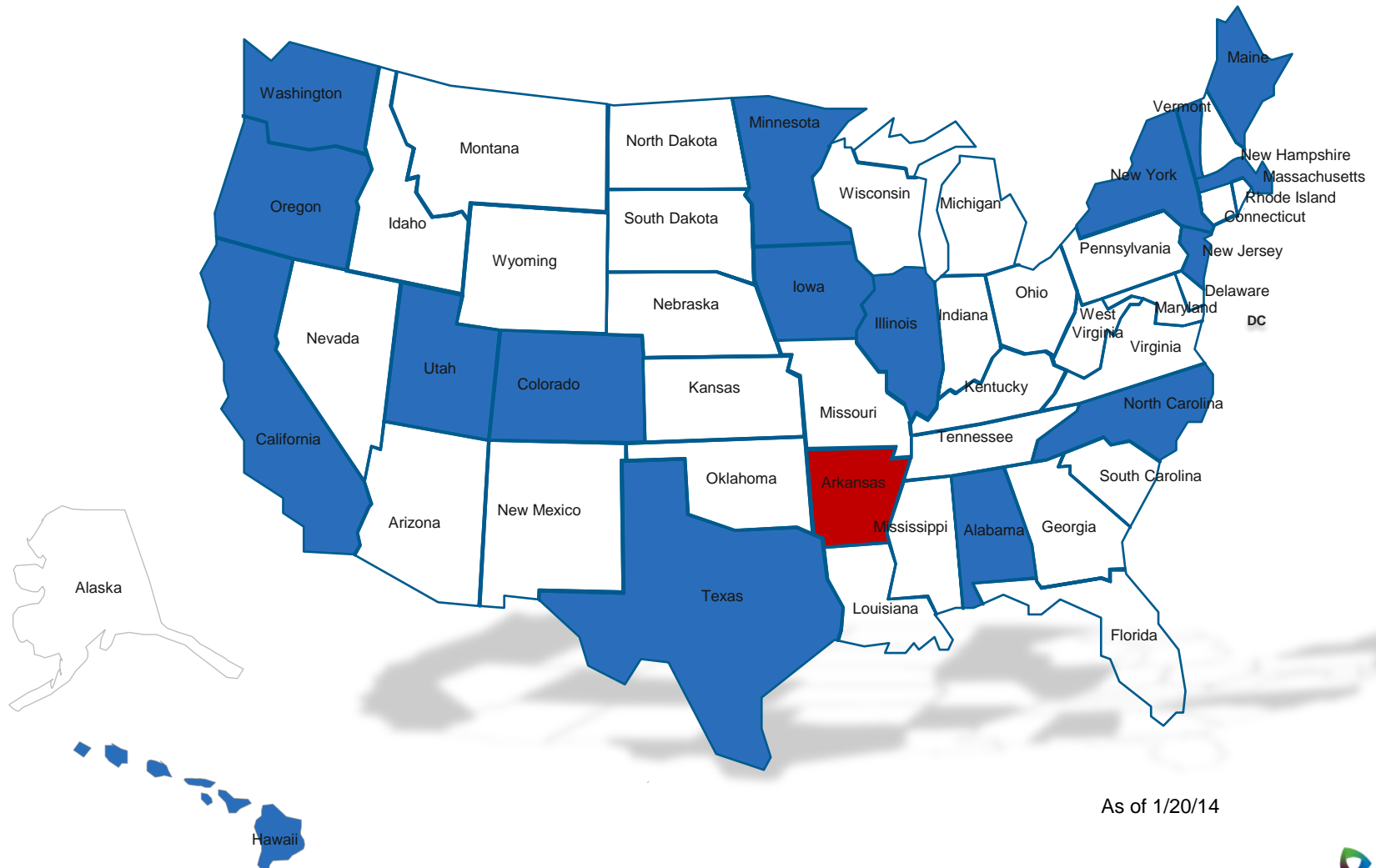
# Medicare ACO Basics

- ▶ Patients are assigned to the ACO based upon their pattern of utilization
- ▶ (No election or lock-in)
- ▶ Minimum 3 year agreement
- ▶ Required to have structure to receive and distribute payments for shared savings
- ▶ Enough Primary Care Physicians (PCPs) and other providers to care for assigned patients (minimum 5,000)
- ▶ Program effective January 1, 2013
- ▶ Participation voluntary for providers
- ▶ PCPs can only participate in one ACO
- ▶ Providers paid fee-for-service payments by CMS
- ▶ Shared savings payments distribution made by ACO

# Medicaid: Payment Reform

ACOs: 17

Bundled Payment: 1





## Accountable Care Collaborative (ACC) model



Regional Care Collaborative Organizations (RCCOs)



Statewide Data Analytics Contractor (SDAC)

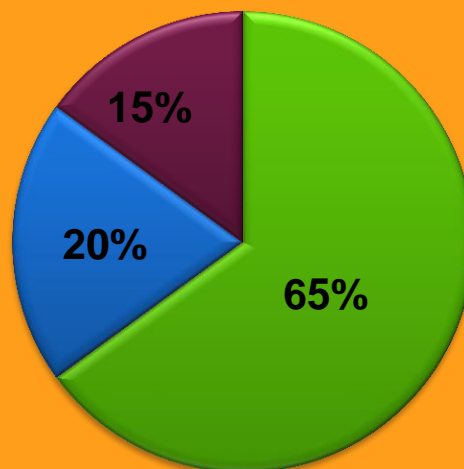


Primary Care Medical Providers (PCMPs)



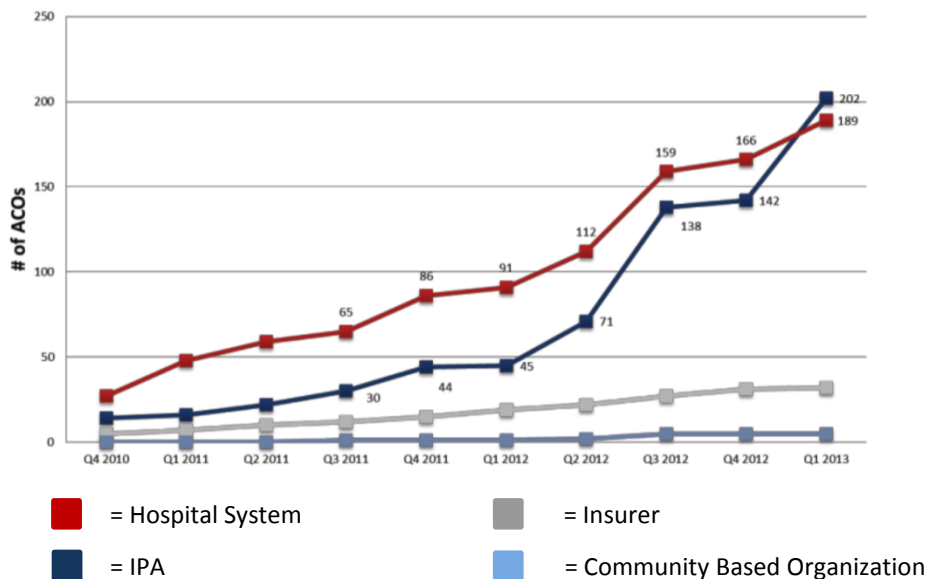
## Per member per month distribution of payments

■ RCCO ■ PCMP ■ Contractor

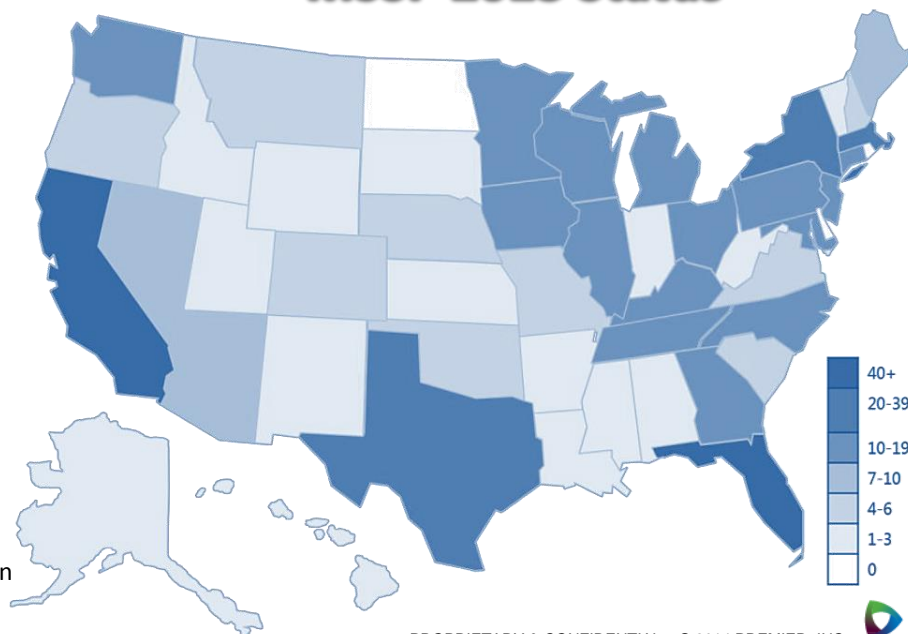


# ACO development accelerating nationwide

- Estimated over 600 public and private ACOs in nearly every state
- Medicare specific ACOs:
  - First ACOs (10 organizations) part of the PGP demonstration project beginning in 2006
  - 32 CMMI “Pioneer” participants, program began 1/1/2012; 9 dropped out with 7 converting to MSSP 1/1/2013
  - Medicare Shared Savings Program
    - 4/1/2012: 27 ACOs added
    - 7/1/2012: 89 ACOs added
    - 1/1/2013: 106 ACOs added
    - **1/1/2014: 123 ACOs added**



## MSSP 2013 Status



# Pioneer ACO year one results

The Pioneer ACO Model is designed for providers that want to accept more risk in order to reap more reward. These groups are effectively “cutting edge” providers—mature ACOs that are already coordinating care.



Costs for the more than 669,000 beneficiaries cared for by Pioneer ACOs grew by only 0.3 percent in 2012, compared to 0.8 percent the for a similar patient population.



13 of the 32 ACOs achieved savings that it shared with CMS.



Generated gross savings of \$87.6 million in 2012, with \$33 million going to the Medicare Trust Funds. Only two Pioneer ACOs incurred shared losses which totaled \$4.0 million.



All participating organizations also earned incentive payments for successfully reporting quality measures for the first year.

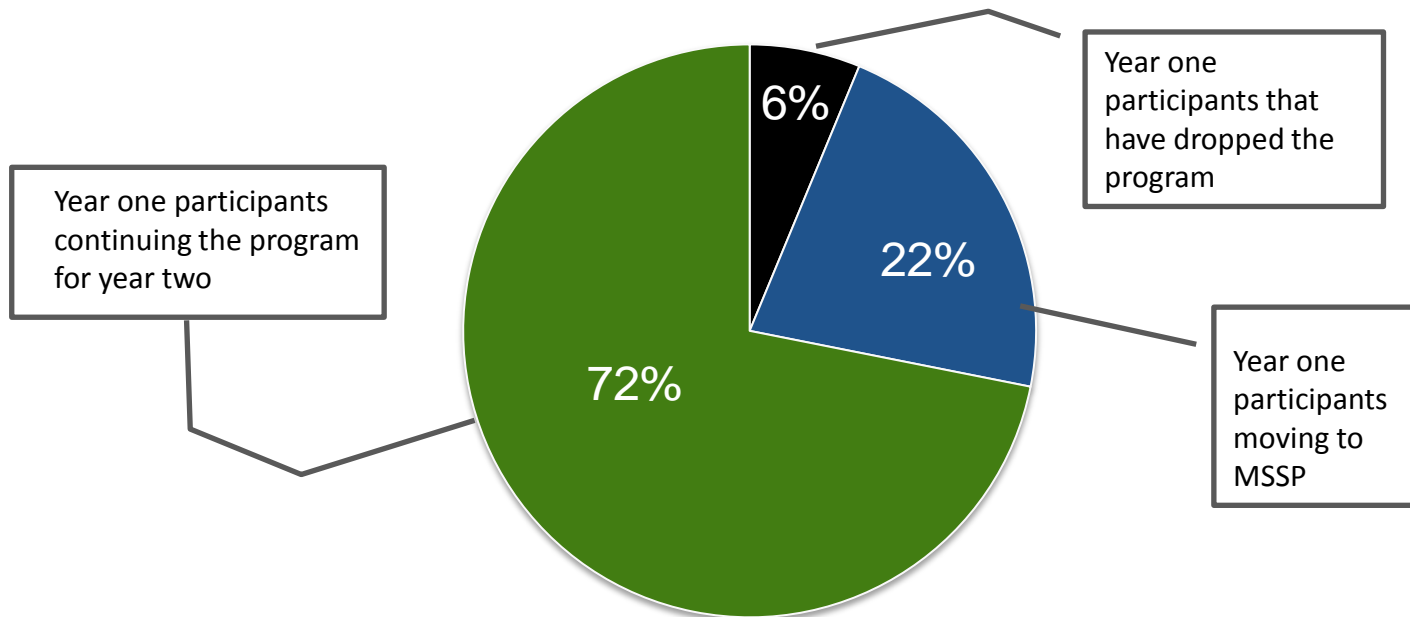


25 of 32 Pioneer ACOs achieved lower readmission rates than the benchmark rates

## Some Pioneers have left the program

### Of 32 first year Pioneer participants -

- ▶ Twenty-three Pioneer participants will remain in the program for year two.
- ▶ Seven first year Pioneer participants are dropping out and moving to the Medicare Shared Savings Program (MSSP) – a program with more easily achievable goals and no risk of losing money if benchmarks are not met.
- ▶ Two Pioneer participants dropped out and will not transition to MSSP.





# Nothing Happens in a Vacuum

---

## **Ongoing financial pressures:**

- ▶ In 2014, PPACA will introduce 30M+ newly insured to U.S. healthcare system
- ▶ Payment reductions driven by federal deficit and the economy
- ▶ Reduced inpatient hospital admissions

## **Increasing focus on value and quality:**

- ▶ Ongoing transition toward value-based payment models
- ▶ Increased regulatory complexity leading to greater transparency
- ▶ Accountable care organization expansions

## **Collaboration and consolidation on the rise:**

- ▶ Blending of delivery systems, health insurance plans, and technology firms
- ▶ Consolidation of hospitals, health systems, and the continuum of care
- ▶ Shifting of Medicaid plan management to private sector managed care plans

## **Significant investments in IT to continue:**

- ▶ Growing administrative burden is compelling modernization of processes and data, and automation of regulatory and service level compliance
- ▶ Information technology will drive data integration and care redesign

# Challenges



Managing in two payment worlds



Dominant payer resistance



Medicare/Medicaid beneficiary engagement



Behavioral health integration



Specialty physician engagement



EMR integration



Speed of Clinical transformation



Transitions of care



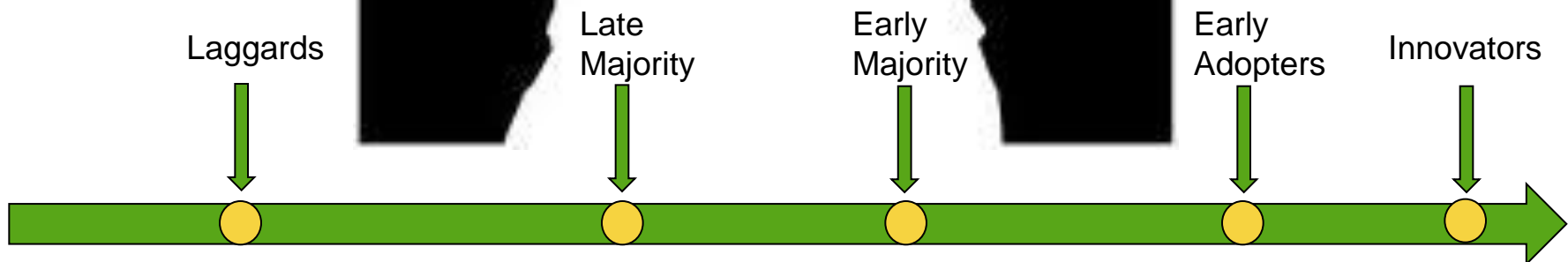
Aligning the employed physician compensation

# ▶ Transitions are Difficult

- Pay for volume
- Fragmented care
- FFS
- Treating sickness
- Adversarial payors
- Little HIT
- Duplication & waste



- Pay for value
- Coordinated care
- Global payment
- Fostering wellness
- Payer partners
- Fully wired systems
- Right care, right setting, right time





# Premier / Commonwealth Fund ACO Case Studies:

## Lessons learned

Managing populations requires fundamental change in health delivery.

The focus of primary transformation should be aligning clinical with payment.

Physician leadership and engagement is pivotal in the shift to accountable care.

Care models and coordination are critical building blocks to success under value-based reimbursement models.

Executive leadership with Governance support is vital to success.

Comprehensive, coordinated primary care services and integrated IT systems are key ingredients for success.

Market pressures can create opportunities for novel partnerships that serve both parties well.

The pace of execution will be limited by payer readiness to participate in innovative, value-based reimbursement models.



# Questions?

Jennifer Flynn

Senior Director, State Affairs

**Premier healthcare alliance**

[Jennifer\\_flynn@premierinc.com](mailto:Jennifer_flynn@premierinc.com)

202.879.8013

