Reform School: ACO and CCO 101

Presented to the Annual Conference of

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Presented by

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Objectives

- *Breathe deeply together and relax in the face of unprecedented change, unknown and uncertainty.*
- *Tune in, turn on and engage our inner entrepreneurs and innovators*

1. **Set the Context**
2. **Define ACO**
3. **Explore the Form and Function**
4. **Review the Fundamentals**
5. **Discuss Next Steps for Providers**

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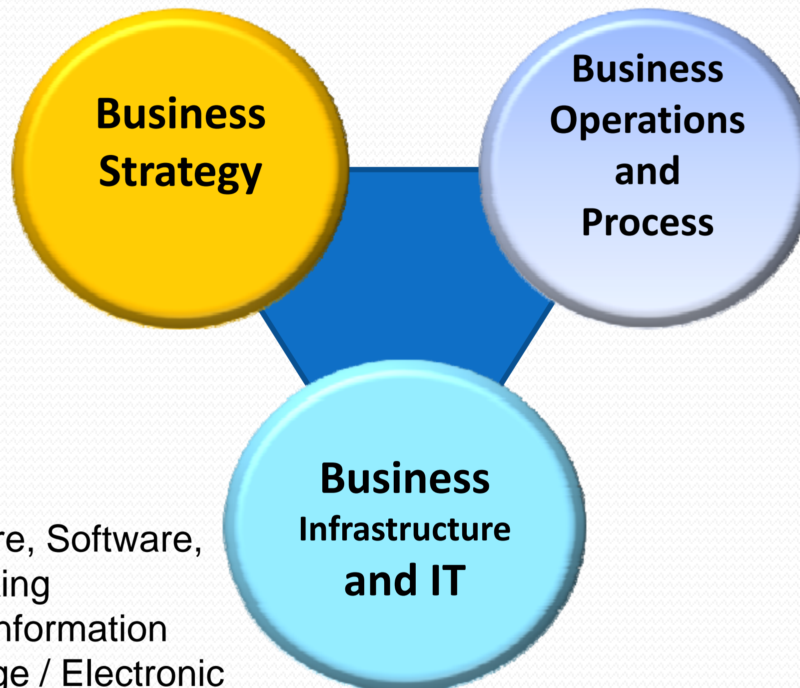
The New Business Environment: The Context for *Business Architecture*

- ✓ Vision
- ✓ Business Plan
- ✓ Leadership
- ✓ Communication
- ✓ Transformation and Innovation Drive
- ✓ Marketing
- ✓ Payer/Patient and Funding Mix



- ✓ Staffing
- ✓ Workflow and Business Process
- ✓ Managed Care Functions
- ✓ Billing and Revenue Mgmt
- ✓ Integration

- ✓ Hardware, Software, Networking
- ✓ Health Information Exchange / Electronic Data Interchange
- ✓ Information Mgmt
- ✓ Data Analysis & Metrics
- ✓ Communications infrastructure

Setting the Context: Multiple Chronic Conditions

- The proportion of Medicaid beneficiaries with disabilities who are **diagnosed with three or more chronic conditions ranges between 35% and 45%.**
- **The frequency of psychiatric illness among Medicaid beneficiaries with disabilities ranges from 29% to 49%.**
- **Psychiatric illness is represented in three of the top five most prevalent pairs of diseases**, or dyads, among the **highest-cost** 5% of Medicaid beneficiaries.

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Multiple Chronic Conditions

- With five years of diagnostic data, two-thirds (67%) of Medicaid-only beneficiaries with disabilities have three or more chronic conditions, more than twice the 29% identified through only one year of data.
- This speaks to the *chronic* nature of these conditions as well as to the critical value of longitudinal data.
- It also speaks to the importance of identifying and treating this population in ACOs.

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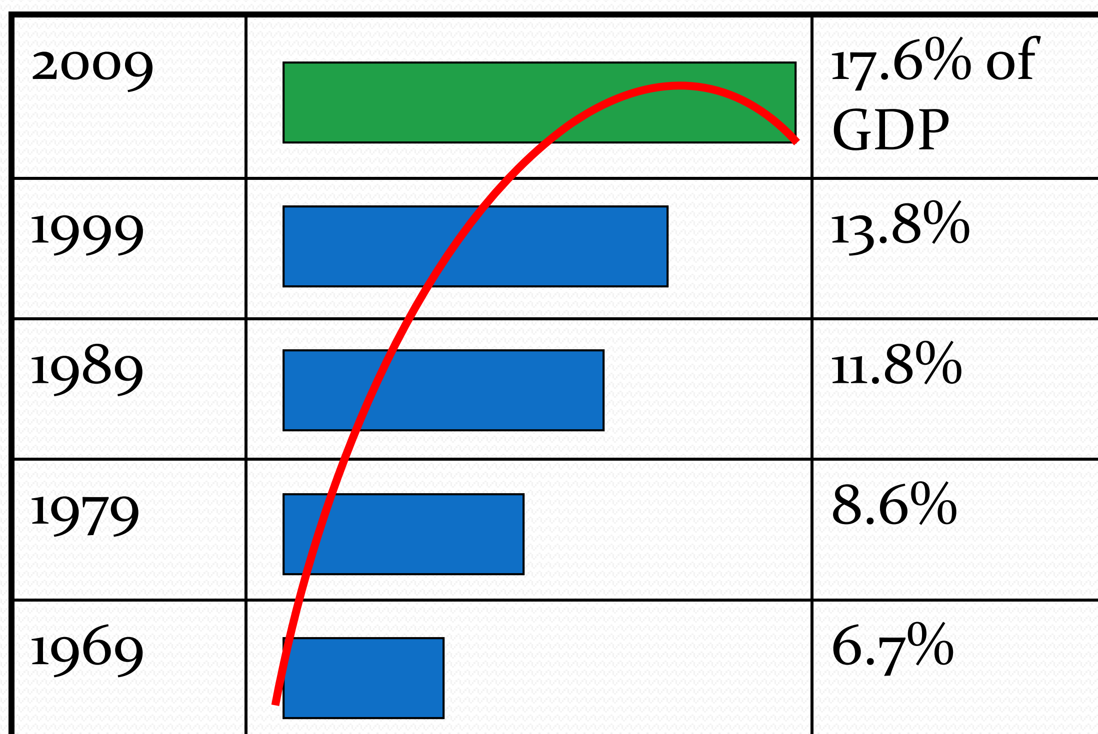
Setting the Context:

The **Cost** of Health Care in America



Year		% of GDP
2009		17.6% of GDP
1999		13.8%
1989		11.8%
1979		8.6%
1969		6.7%

Source: CMS, Office of the Actuary, National Health Statistics Group

Setting the Context: Affordable Care Act

“Health Care Reform”

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Reform

- Increases access – *requires* benchmark/essential benefit
  - 16+ M through Medicaid (<133% poverty)
  - 16+ M get affordable private coverage thru HI Exchanges (<400%)
  - Adds coverage through age 26 for dependents
  - Eliminates pre-existing conditions clauses (right away for children)
  - Requires guaranteed issue and renewal
- Adds preventive services (no cost sharing for depression and SUD screens)
- Controlling costs, improving quality, focusing on value/outcomes
- Opportunity to integrating acute care & wrap-around recovery support services

Reform

- Medicaid and Integration
  - Health care homes for those w. co-morbidities
  - Primary care services integrated w. specialty care
    - Service co-location opportunities ($50M for demos)
- Medicaid-Medicare integration/improvements
  - Health promotion (e.g., tobacco cessation) programs – reducing risk for preventable diseases
  - Prescription drugs (Part D and the “doughnut hole”)
  - Accountable Care Organization pilots

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Reforms

- **Small businesses:** Small businesses tax credit makes premiums more affordable for small employers already providing benefits.
- **Reduces uncompensated care**. Right now, providers lose billions in uncompensated care each year. Instead, under reform, uncompensated care would begin to be reduced immediately as more uninsured people gain coverage.
- **Extends Parity.** All Health Insurance Exchanges that sell policies to small groups and individuals will have to comply with MHPAEA. Medicaid managed care plans will as well and we can expect an *"Essential Benefit"* design in the future.

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Impact on Coverage Expansion

Prior to implementation of coverage expansion:

- 39% of individuals served by State Mental Health Authorities have no insurance
- 61% of the individuals served by State Substance Abuse Agencies have no insurance

Many of these individuals will be covered in 2014 (or sooner)—most likely by the expansion in Medicaid

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Setting the Context: ACOs

- On March 31, 2011, the Centers for Medicare & Medicaid Services (CMS), an agency within the Department of Health and Human Services (HHS), proposed new rules under the Affordable Care Act to help doctors, hospitals, and other health care providers better coordinate care for Medicare patients through Accountable Care Organizations (ACOs).

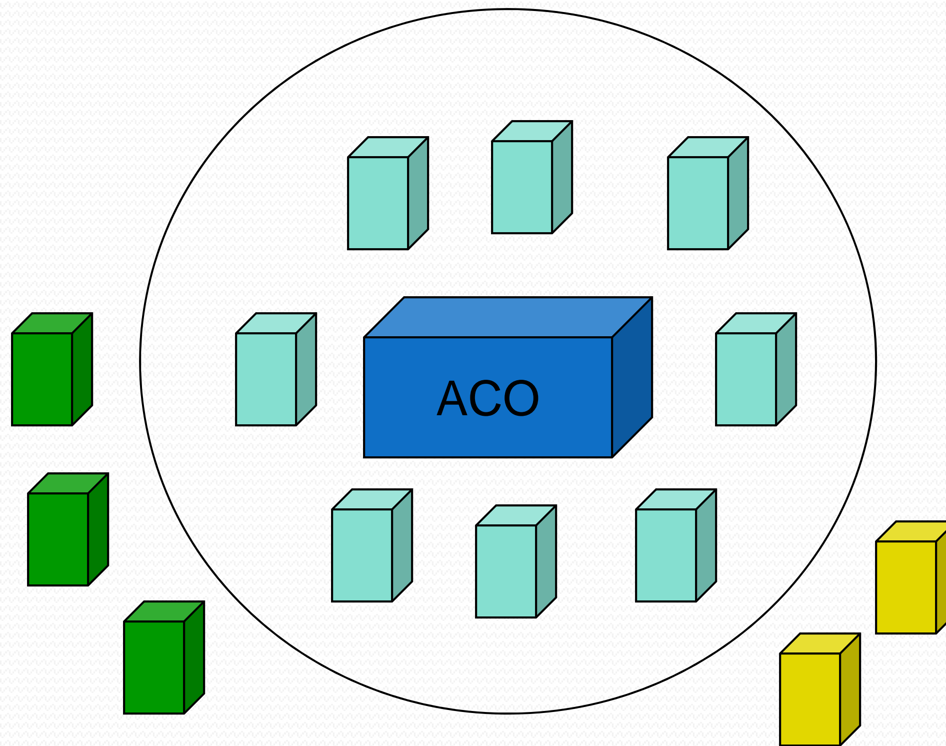
- ACOs create incentives for health care providers to work together to treat an individual patient across care settings – including doctor's offices, hospitals, and long-term care facilities. **The Medicare Shared Savings Program** will reward ACOs that lower growth in health care costs while meeting performance standards on quality of care and putting patients first. Patient and provider participation in an ACO is purely voluntary.

- In developing the proposed rule, CMS has worked closely with agencies across the Federal government to ensure a coordinated and aligned inter- and intra-agency effort to facilitate implementation of the Medicare Shared Savings Program (Shared Savings Program).

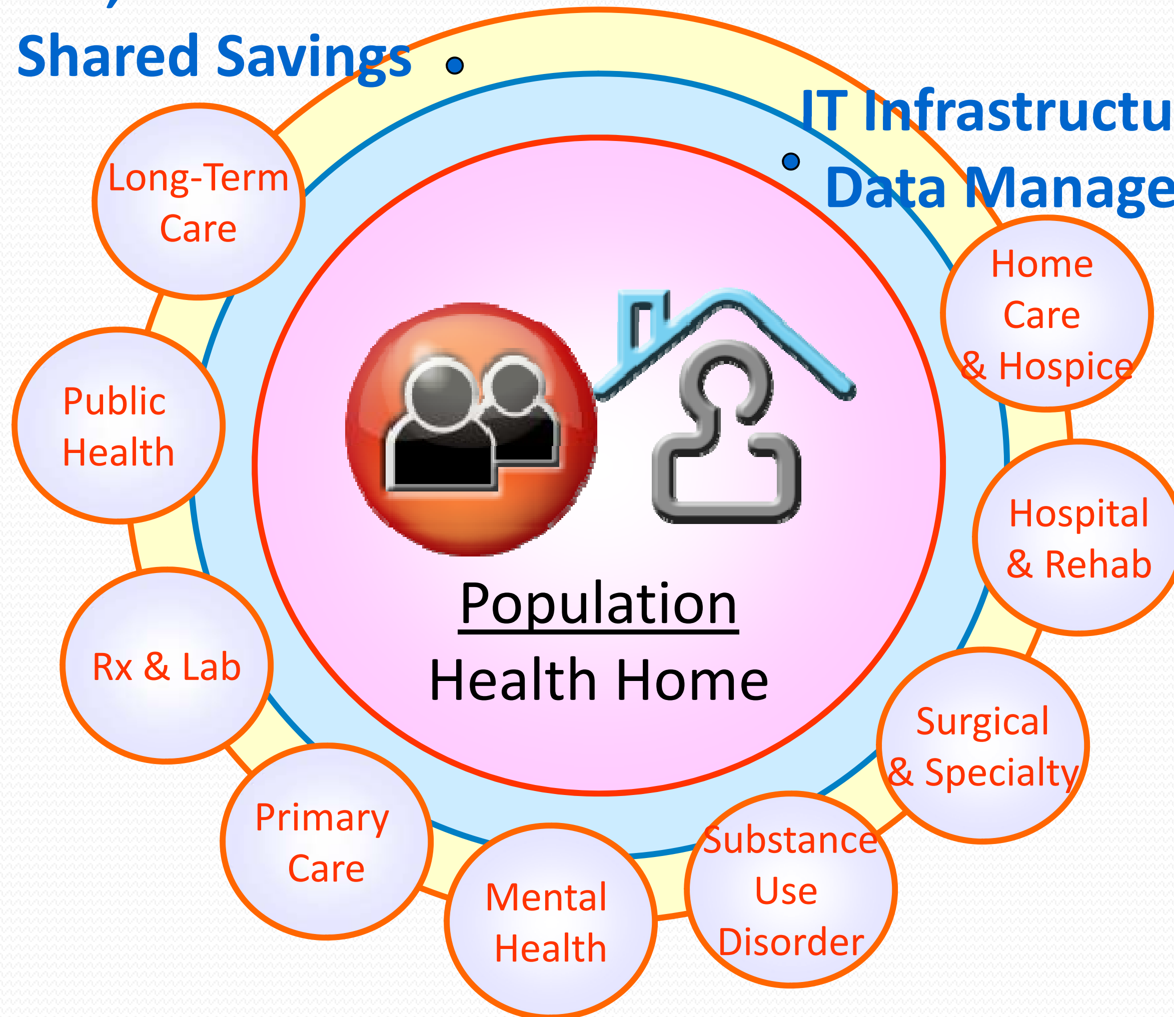
ACOs Defined

- **Q: What is an “accountable care organization”?**
- **A:** An Accountable Care Organization, also called an “ACO” for short, is an organization of health care providers (a “health system” or “integrated delivery system”) that agrees to be accountable for the quality, cost, and overall care of Medicare beneficiaries who are enrolled in the traditional fee-for-service program who are assigned to it.
- For ACO purposes, “assigned” means those beneficiaries for whom the professionals in the ACO provide the bulk of primary care services. Assignment will be invisible to the beneficiary, and will not affect their guaranteed benefits or choice of doctor. A beneficiary may continue to seek services from the physicians and other providers of their choice, whether or not the physician or provider is a part of an ACO.

What is an Integrated Delivery System of Care?



ACO



ACO Goals

- Promote development of **new systems** of care
- Change provider culture and incentives from fragmented FFS
- Avoid adverse affects on existing systems that already provide accountable care
- **Lower costs** while **improving population health**
- Measure both **quality** and **financial** performance
- Hold provider systems accountable for both cost and quality of care for **assigned patient populations**

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ACO Innovations

Minimize “barriers to entry” for patients and providers:

- Patients attributed, not enrolled
- No benefit or network restrictions; no lock-in; no prior-auth

Flexibility for providers to form different kinds of ACOs

- Flexible payment model
  - Bundled payments
  - Fee-for-service with shared risk (two tracks)
  - Pay-for-Performance
  - Full and partial capitation

Receiving shared savings requires first achieving quality threshold

ACO Proposed Regulations

- The proposed rule would require the ACO to have in place procedures and processes to promote evidence-based medicine and beneficiary engagement in their care.
- The proposed rule would require ACOs to report quality measures to CMS and give timely feedback to providers.
- CMS expects that ACOs will invest continually in the workforce and in team-based care.
- To assure program transparency, the proposed rule would require ACOs to publicly report certain aspects of their performance and operations.
- The proposed rule would establish quality performance measures and a methodology for linking quality and financial performance that will set a high bar on delivering coordinated and patient-centered care by ACOs, and emphasize continuous improvement around the three-part aim of:
  1. **better care for individuals**
  2. **better health for populations**
  3. **lower growth in expenditures.**

ACO Reimbursement

- Under the proposed rule, Medicare would continue to pay individual providers and suppliers for specific items and services as it currently does under the fee-for-service payment systems.
- The proposed rule would require CMS to develop a benchmark for savings to be achieved by each ACO if the ACO is to receive shared savings, or be held liable for losses.

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Two Tracks for ACOs

- To provide an entry point for organizations with varied levels of experience with and willingness to take on risk, the proposed rule would allow an ACO to choose one of two program tracks.
- The **first track** would allow an ACO to operate on a *shared savings only* track for the first two years, but would then require the ACO to assume the risk for shared losses in the third year.
- The **second track** would allow ACOs to share in savings and risk liability for losses beginning in their first performance year, in return for a higher share of any savings it generates.

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ACO Q&A

- **Q: What forms of organizations may become an ACO?**

- **A:** The statute specifies the following:

1. ACO professionals (i.e., physicians and hospitals meeting the statutory definition) in group practice arrangements,
2. Networks of individual practices of ACO professionals,
3. Partnerships or joint ventures arrangements between hospitals and ACO professionals, or
4. Hospitals employing ACO professionals.
5. Other Medicare providers and suppliers as determined by the Secretary

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ACO Q&A

- **Q: What are the types of requirements that such an organization will have to meet to participate?**

- **A:** The statute specifies the following:

1) Have a formal legal structure to receive and distribute shared savings
2) Have a sufficient number of primary care professionals for the number of assigned beneficiaries (to be 5,000 at a minimum)
3) Agree to participate in the program for not less than a 3-year period

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ACO – requirements cont'd

4) Have sufficient information regarding participating ACO health care professionals as the Secretary determines necessary to support beneficiary assignment and for the determination of payments for shared savings.

5) Have a leadership and management structure that includes clinical and administrative systems

6) Have defined processes to (a) promote evidenced-based medicine, (b) report the necessary data to evaluate quality and cost measures (this could incorporate requirements of other programs, such as the Physician Quality Reporting Initiative (PQRI), Electronic Prescribing (eRx), and Electronic Health Records (EHR), and (c) coordinate care

7) Demonstrate it meets patient-centeredness criteria, as determined by the Secretary.

- **Q: How would such an organization qualify for shared savings?**

- **A:** For each 12-month period, participating ACOs that meet specified quality performance standards will be eligible to receive a share of any savings if the actual per capita expenditures of their assigned Medicare beneficiaries are a sufficient percentage below their specified benchmark amount. The benchmark for each ACO will be based on the most recent available three years of per-beneficiary expenditures for Parts A and B services for Medicare fee-for-service beneficiaries assigned to the ACO.

ACO Q&A

- **Q: Will beneficiaries that receive services from a health care professional or provider that is a part of an ACO be required to receive all his/her services from the ACO?**

- **A:** No. Medicare beneficiaries will continue to be able to choose their health care professionals and other providers

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ACO Q&A

- **Q: When will this program begin?**

- **A:** January 1, 2012. Agreements will begin for performance periods, to be at least three years, on or after that date.

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- *Per NCQA*
  - **Program Structure Operations:** Clearly defined organizational and leadership structure. The ACO arranges for pertinent healthcare services and determines payment arrangements and contracting.
  - **Access and Availability:** The organization ensures that it has sufficient numbers and types of practitioners who provide primary and specialty care.
  - **Primary Care:** Primary care practices within the ACO provide patient-centered care.
  - **Care Management:**
    - The organization collects and integrates data from various sources, including, but not limited to electronic sources for clinical and administrative purposes.
    - The organization conducts an initial assessment of new patients' health.
    - The organization uses appropriate data to identify population health needs and implements programs as necessary.
    - The organization provides resources for, or supports, the use of patient care registries, electronic prescribing and patient self-management.

Core Capabilities

- *Per NCQA*
  - **Care Coordination and Transitions:** The organization can facilitate timely information exchange between primary care, specialty care and hospitals for care coordination and transitions.
  - **Patient Rights and Responsibilities:** The organization has a policy that states its commitment to treating patients in a manner that respects their rights, its expectations of patients' responsibilities, and privacy. A method is provided to handle complaints and to maintain privacy of sensitive information.
  - **Performance Reporting:** The organization measures and reports clinical quality of care, patient experience, and cost. At least annually, the organization measures and analyzes the areas of performance and takes action to improve effectiveness in key areas.

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- Clinical pathways
- Care coordinators and navigators
- Medical/health care home model
- Certified EHR, certified *Meaningful Use* capabilities, and health information exchange (HIE)

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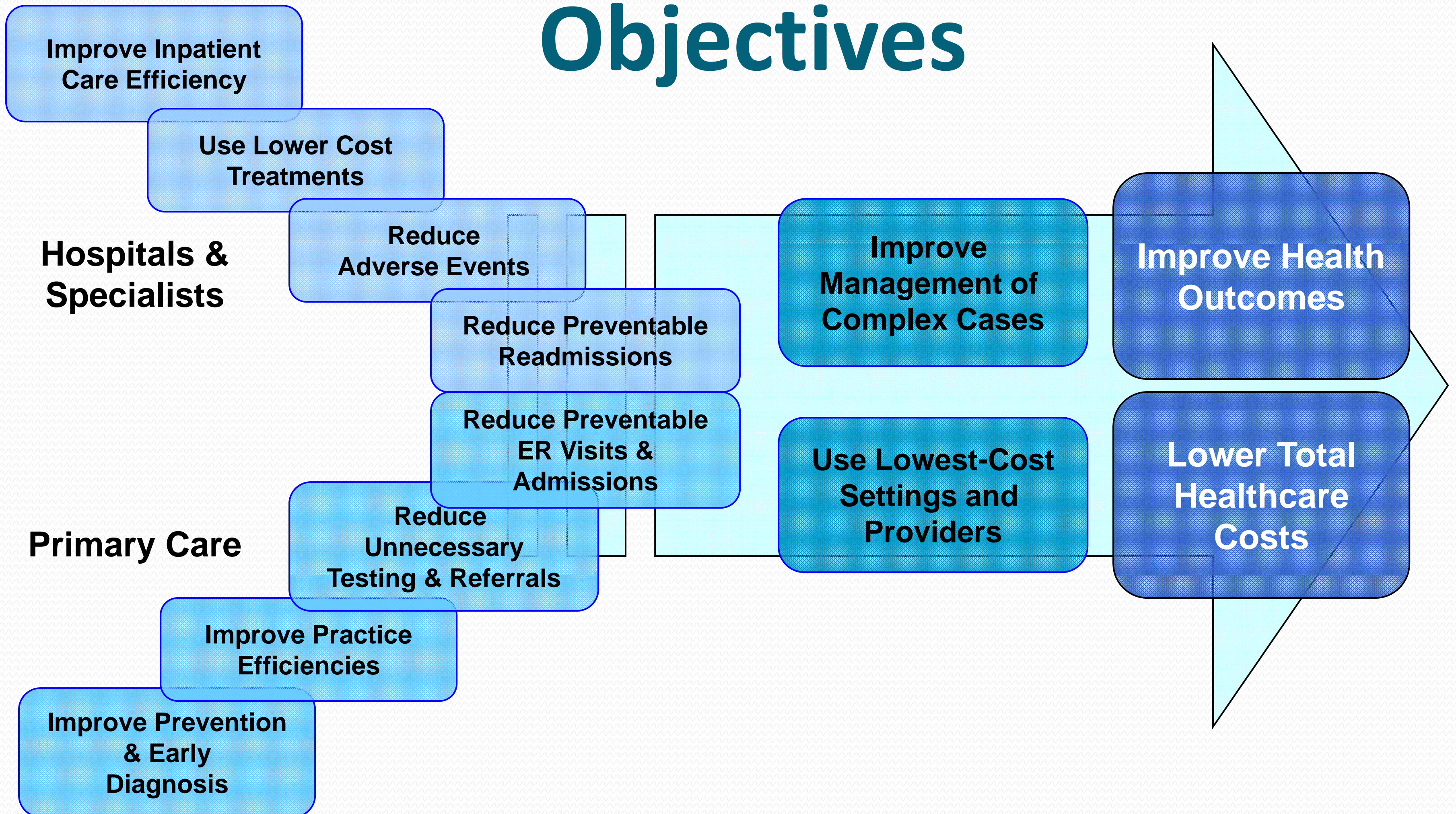
Goals & Objectives



Four Levels of ACO

- **Level 1 ACO:** Primary care practices functioning together through an IPA or other organizational mechanism and focusing on prevention and improvement of care for ambulatory care-sensitive conditions.
- **Level 2 ACO:** Primary care practices and frequently-used specialties, working together through an IPA or multi-specialty group practice, and focusing on prevention and improvement of care for ambulatory care-sensitive conditions and common specialty procedures.
- **Level 3 ACO:** Primary care practices, specialists, and hospitals, working together through an integrated delivery system or other organizational mechanism, and focusing on all or most opportunities for cost reduction and quality improvement.
- **Level 4 ACO:** Healthcare providers, public health agencies, and social service organizations working jointly to improve outcomes for a very broad patient population, including homeless individuals and the uninsured.

- Kaiser Permanente
- Geisinger Health System
- Cleveland Clinic

Population Health Management

- ACOs must develop a process for identifying patients who have complex needs (multiple chronic conditions) or are at high risk of developing such needs and provide them with wellness and prevention programs, disease management, and complex case management, as indicated
- ACOs must make available or support providers' use of electronic prescribing, electronic health records systems, registries, and self-management tools
- *MH/SUD providers must be prepared to work in this environment and develop the necessary tools and resources*

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Incentives to Participate

- Identified population/market share
- Some administrative fees for administrative duties
- Reliable referral sources within network
- Common values and objectives (coordination, cooperation, collaboration)
- Shared information (whole health)
- Shared savings (financial incentives)

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Establishing Readiness and Capabilities for ACOs

- **Organizational Structure and Financial Infrastructure** – Integrated Delivery System that can track performance and payments
- **Reporting Infrastructure** – UM, DM, CM as well as utilization and practice trends
- **Performance Management** – disease-specific dashboards, baselines, benchmarks and demonstrated fidelity with evidence-based practices
- **Data Aggregation** – data warehousing, interoperability, shared disease registries
- **Clinical Data Exchange** – shared procedures, discharge plans, care coordination, monitoring/follow-up, shared treatment history
- **Security** – secure access to administrative and clinical data based on authorized "roles" and authentication protocols

Establishing Readiness and Capabilities for Market Innovations

Information Technology Components

- Certified EMR, EHR and *Meaningful Use* of Health Information
- Pervasive Connectivity/Networking
- Data Analytics and Predictive Modeling
- Disease and Case Management Software Applications (clinical decision support)

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Top Drivers for ACO Involvement

1. A better structure for clinical integration is needed
2. Public and private payers need to shift risk to providers
3. Market competition is driving integration

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Markets for ACOs

- Medicare (2012)
- Medicaid (CCO)
- Commercial health plans
- Employers

The Big Picture – Strategic Planning

- **Vision** – what will you become?
- **Mission** – how will you become what you envision?
- **Goals** – what incremental achievements will enable you to satisfy your mission?
- **Objectives** – what tactical steps will enable you to meet your goals?

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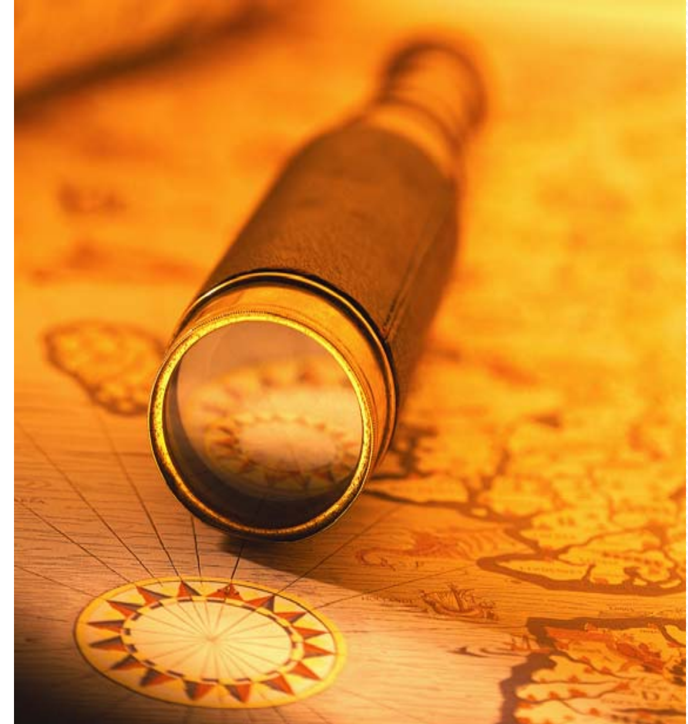
Keep Your Eye on…

1. National/State/County Situation Analysis (budgets, budgets, budgets!)
2. Comparing and contrasting State and Federal laws and Final Rules
3. Guidance coming from insurance commissioner, HFS, health plans and ERISA groups (self-insured employers)
4. Clarifying scope of service questions, Essential Health Benefits and Essential Community Providers
5. State Lawsuits, Medicaid Plans and Waivers, Health Insurance Exchange
6. Efforts to standardize and normalize
7. Aligning incentives, Global Reimbursement
8. Financing the technology transformation



Market Research

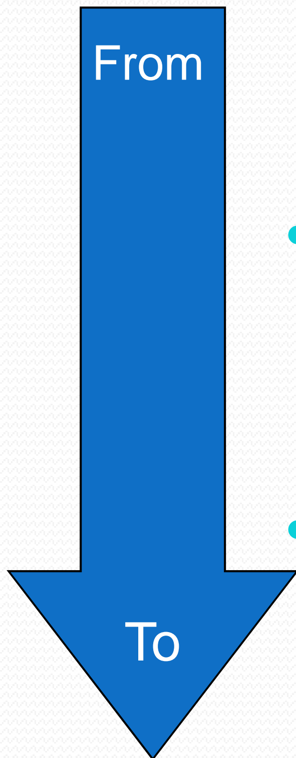
Sources of Valuable Information

- **Health Plans and Managed Care Organizations**
  - State Department of Insurance
  - AHIP and State Associations of Health Insurance Plans
- **Self-Insured Employers**
  - National and Regional Business Group on Health
  - Employers’ Health Coalitions
- **Federal and State Agencies**
  - HFS, CMS, SAMHSA

Market Segments

- Commercial Insurance / Public Funding
- Voluntary / Involuntary
- Geographic Markets
- Age
- Gender
- Specialty / Generalist / One-Stop Shop
- Race / Culture / Language
- Stand-Alone / Integrated / Joint Venture / Partnership
- Faith-Based

Business Model Innovations



- **Solution Shop** – fee-for-service expertise to diagnose and solve unstructured problems (imaging centers, law firms, consultants). Charge for cost of inputs (expert time). Focus on diagnosis.

- **Value-Add Process (VAP)** – assembling solutions of higher value (restaurants, retailers, auto-makers). Charge for value of outputs (assembled products). Focus on treatment after diagnosis. Clinics and the use of less expensive “experts” are good examples of VAP.

- **Facilitated Networks** – models wherein people exchange things with one another (insurance, mutual funds, eBay and WebMD are examples). WebMD has begun building communities of people with certain chronic conditions like diabetes. These models harness vast amounts of data and technology architecture.

Source: C. Christensen

New Conversations

- Hospitals
- Health Plans and MCOs/MBHOs
- Primary Care
- Third-Party Administrators
- Brokers
- Networks
- Employers
- Other Medical Specialists
- **Others?**

New Conversations

1. Professional
2. Face-to-face
3. Expressing willingness and interest
4. Demonstrating *big picture* understanding and prospect of synergies
5. Eager to develop viable, marketable, attractive solutions
6. Promoting new services and potential new business model
7. Clear, distinct, customer value proposition
8. Potential collaborator? Investor? Partner? Buyer?
9. Benefits and advantages more important than features and functions
10. Always Branding

Potential Barriers

- Procrastination among leaders (sitting on your hands)
- Misunderstanding and need for expertise
- Culture and history of working at the margins
- Administrative and “development” costs
- Resistance of clinical staff
- Financial risks
- Lack of certified, interoperable EHR system

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Next Steps

- ***Enable* your organization for change**
  - Develop a strategic plan, business plan, and *especially* a marketing plan that enables growth in terms of market share and revenue
  - Commit capital, develop a budget, and find investors or partners if you need them
  - Address staffing, outsourcing, and the need for periodic expertise
  - Plan for and implement your technology infrastructure
  - Commit to Performance Mgmt

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Next Steps

- ***Manage* your organization through change**
  - Set the course
  - Establish and measure your expectations
  - Keep distractions and competing priorities to a minimum
  - Hold people (including yourselves) accountable
  - Align efforts so time and energy are not wasted
  - Provide reinforcements, encouragement and rewards (recognition)

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Next Steps

- ***Manage* your organization through change**
  - Become *Learning Organizations* (there is a lot to learn!)
  - Recruit, retain and train the right people in administrative as well as clinical areas
  - Innovate and grow from your *Core Competencies*
  - Encourage some risk-taking, experimentation and tolerate mistakes
  - Conduct market research – *what you don't know can hurt you*
  - Invest in your brand image and "dress the part"
  - Use thoughtful scenario-based business modeling and *business case* approaches to innovations

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Execution – *Answer the Tough Questions*

1. *How – operationally - will you implement the change required of your business model without disrupting current business?*

2. *Do you have adequate human resources and expertise? Can you afford to buy the expertise you lack?*

3. *Is there enough political will to carry out your growth goals?*

4. *Do you have the financial resources to adapt and grow or do you need to find a partner or investors?*

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Living with the Tension

Tension will exist between:

- Markets
- Paradigms: past, present and future
- People vying for roles
- Short and long term needs
- Profits and investments in the future
- The team and the individual
- Dissent and agreement
- “Business” and “Recovery”
- The *“way we’ve always done it”* and innovation

The challenge is one of making the tension creative and productive

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Thank You!
Questions and Contact

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