Accountable Care Organizations

American Association of Diabetic Educators

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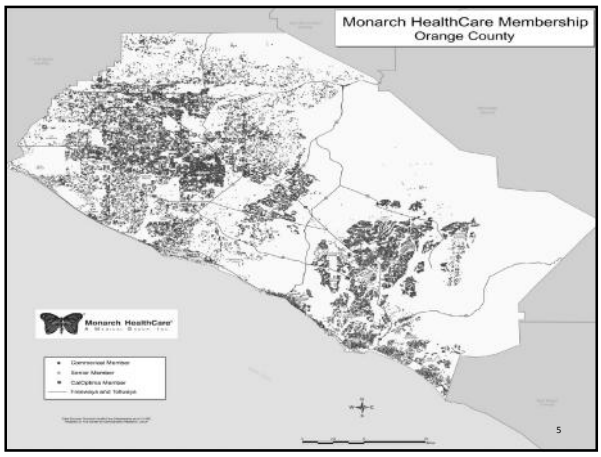
- I have no conflicts of interest to disclose except:
  - I am a recovering Pediatrician!

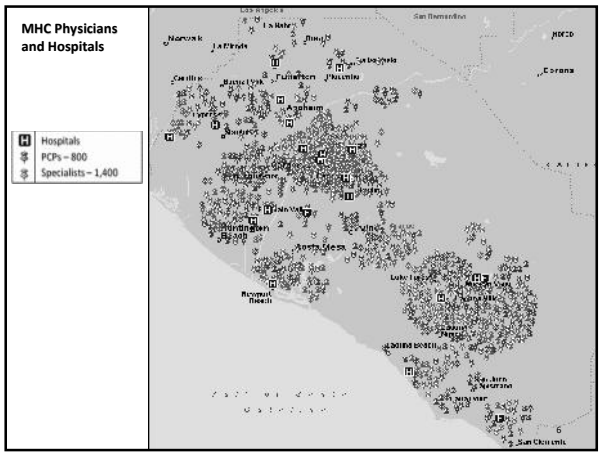
Monarch HealthCare Facts and Figures

- Largest Independent Practice ACO in Orange County and only one with a county-wide presence
- Contracts with all major health plans in California
- Contracts with PCP's and Specialists: >2,200
- 200,000 Patients
  - 118,000 Commercial HMO Members
  - 30,000 ACO Anthem PPO Members
  - 30,000 Senior HMO Members
  - 22,000 MediCal Members
- Multiple hospital relationships

Provider Network

- Over 800 primary care physicians
  - Family Medicine
  - Internal Medicine
  - Pediatrics
- Over 1,400 community based specialists
- 40 employed physicians
- All PCPs are capitated, receiving a monthly payment for each Monarch HMO member under their care
- 35 specialties with aligned incentives in a capitated risk sharing model





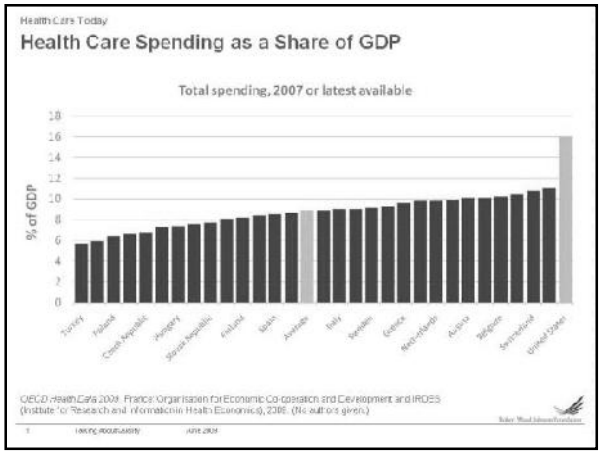
Today's Discussion

- How did we get here and why the status quo is not acceptable?
- One possible solution: The Accountable Care Organization (ACO)
- What is an ACO?
- What this means for you?
- Where do we go from here?

Health Care Today

Hospital Charges (This is real!!!)

Code	Description	Unit Cost	Units	Total Charges
0214	DOU SEMI PRIVATE	$ 2,452.00	2	$ 4,904.00
0250	PHARMACY	$ 11.04	23	$ 254.00
0270	MED-SURG SUPPLIES NON STERILE	$ 48.33	9	$ 435.00
0272	MED-SURG SUPPLIES STERILE	$ 60.15	26	$ 1,564.00
0300	LABORATORY (LAB)	$ 33.50	2	$ 67.00
0301	LAB/CHEMISTRY	$ 228.33	12	$ 2,740.00
0305	LAB/HEMATOLOGY	$ 173.00	3	$ 519.00
0320	RADIOLOGY	$ 662.33	3	$ 1,987.00
0410	RESPIRATORY THERAPY	$ 107.00	4	$ 428.00
0424	PHYSICAL THERAPY EVALUATION	$ 319.00	1	$ 319.00
0450	EMERGENCY ROOM	$ 825.50	2	$ 1,651.00
0460	PULMONARY FUNC	$ 154.00	1	$ 154.00
0482	STRESS TEST	$ 1,403.00	1	$ 1,403.00
0610	MRI	$ 3,165.00	2	$ 6,330.00
0636	DRUGS/DETAIL CODE	$ 70.50	2	$ 141.00
0730	EKG/ECG	$ 305.33	3	$ 916.00
0771	VACCINE ADMIN	$ 166.00	1	$ 166.00
01	Page 1 of 1	Creation Date: 03/03/11	Totals	$ 23,978.00



Overall Ranking

Country Rankings
1.00–2.33
2.34–4.66
4.67–7.00

	AUS	CAN	GER	NETH	NZ	UK	US
OVERALL RANKING (2010)	3	6	4	1	5	2	7
Quality Care	4	7	5	2	1	3	6
Effective Care	2	7	6	3	5	1	4
Safe Care	6	5	3	1	4	2	7
Coordinated Care	4	5	7	2	1	3	6
Patient-Centered Care	2	5	3	6	1	7	4
Access	6.5	5	3	1	4	2	6.5
Cost-Related Problem	6	3.5	3.5	2	5	1	7
Timeliness of Care	6	7	2	1	3	4	5
Efficiency	2	6	5	3	4	1	7
Equity	4	5	3	1	6	2	7
Long, Healthy, Productive Lives	1	2	3	4	5	6	7
Health Expenditures/Capita, 2007	$3,357	$3,895	$3,588	$3,837*	$2,454	$2,992	$7,290

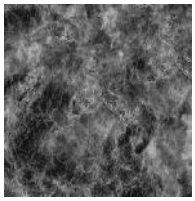
Note: * Estimate. Expenditures shown in $US PPP (purchasing power parity).
Source: Calculated by The Commonwealth Fund based on 2007 International Health Policy Survey; 2008 International Health Policy Survey of Sicker Adults; 2009 International Health Policy Survey of Primary Care Physicians; Commonwealth Fund Commission on a High Performance Health System National Scorecard; and Organization for Economic Cooperation and Development, *OECD Health Data, 2009* (Paris: OECD, Nov. 2009).

The Institute for Healthcare Improvement, 2008

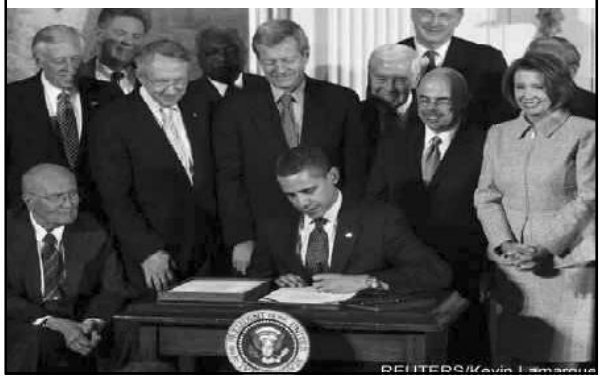
The "Triple Aim"

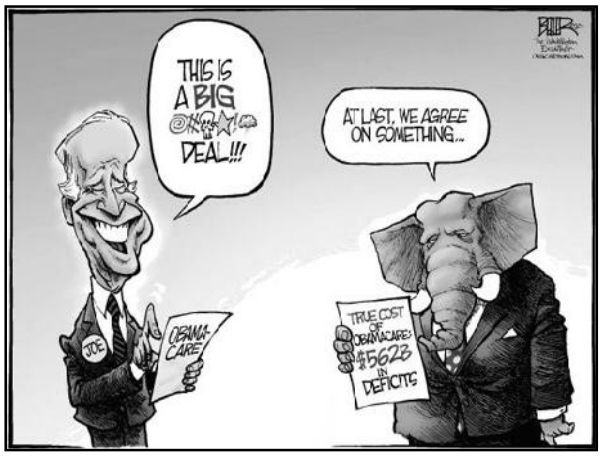
- Improved Population Health
- Improved Care Experience
- Reduced per capita Cost

The Cost Conundrum
The New Yorker, June 1, 2009
Dr. Atul Gawande



Health Care Reform – Now What?





Healthcare Reform: Implications

- Growth in enrollment: senior (boomers), commercial (newly insured) and MediCaid (increases eligibility)
- The nation has initiated its move away from fee-for-service toward the coordinated care (ACO) model
  - Innovation in delivery systems and payment methodology will be rewarded
  - Effective care management and care coordination will be critical
- Accountable Care Organizations, in various forms, will develop across the county

What is an Accountable Care Organization?

Accountable Care

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Dartmouth Institute for Health Policy

Current System	Accountable Care System
Fragmentation	Integration
Adversarial	Cooperation
Focus on "doing"	Managing a population
One-to-one care	Team-based care
Gatekeeper	System management
Perverse $ incentives	Aligned $ incentives
Volume/intensity	Quality and efficiency

Accountable for What?

- Coordinating care across the continuum
- Teams of providers accountable for the outcomes of populations of patients with a "local" flair
- Value placed on coordination, prevention, and communication
- **Tremendous opportunity to capitalize on existing care coordination principles and the use of innovative approaches to population health**

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Accountable Care Organizations: High Level Requirements

- ü Track record of strong financial performance and adequate financial reserves, and the ability to take risk and distribute shared savings
- ü Meet all legal and regulatory requirements
- ü Investment in IT systems, with data warehouse and enterprise-wide connectivity
- ü Demonstrated ability to successfully manage hospital and payer relationships
- ü Capable of value-added care coordination for patients

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The ACO Simplified

"THE HOME FOR THE MEDICAL HOME"

We All Have to Change

- **Providers**
  - Improve outcomes and satisfaction
  - Decrease costs and waste
  - Coordinate care
- **Payers/Employers**
  - Encourage prevention and compliance
  - Value-based benefit design
  - Reward value
- **Patients**
  - Healthy lifestyles
  - Compliance
  - Financial stake
- **Government**
  - Ensure transparency
  - Pay for value
  - Help for those in need
  - Support research and education

*From Mayo Clinic Health Policy Center, 2010

What Types of ACO's Might I See?

Commercial PPO ACO's

DARTMOUTH

Anthem
Health. Join in.

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Dartmouth-Brookings ACO Pilot Sites

Carilion Clinic Roanoke, VA	Norton Healthcare Louisville, KY	Tucson Medical Center Tucson, AZ
• ~900 Providers • 37,000 Medicare Patients Assigned	• ~400 Providers • 20,000 Medicare Patients Assigned	• ~80 Providers • 7,000 Medicare Patients Assigned

CALIFORNIA ACOs

Monarch HealthCare Based in Irvine, CA	HealthCare Partners Based in Torrance, CA
• Medical Group & IPA • >800 PCPs • >2,500 contracted, independent physicians • ACO will cover Orange County	• Medical Group & IPA • >1,200 employed and affiliated PCPs • >3,000 employed and contracted specialists • ACO will cover LA County

Data Source: Dartmouth Institute & Brookings Institution

Medicare Shared Savings ACO

Medicare

Medicare Shared Savings Program

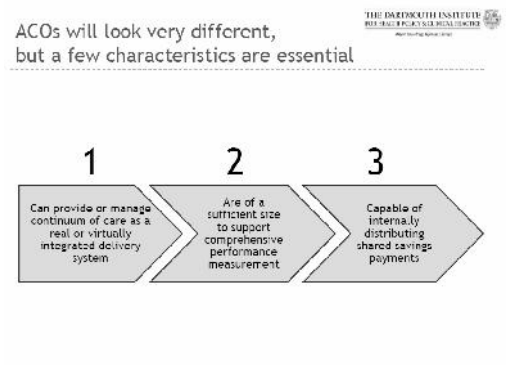
- ACOs continue to receive high profile as an expedient solution to Medicare's cost and quality issues
- Due to start 1/1/12
- March 31 2011: "Draft" 429 page Medicare Shared Savings Program (MSSP) ACO regulations released
  - Revisions due shortly

Pioneer ACO's

CMMI* Pioneer ACO Model

- Specifically designed for organizations with experience coordinating care
- Three (3) 12-month performance periods
  - Extendable for 2 additional 12-mo periods
- Up to 30 organizations will be accepted
- Shared savings payments move into "population-based" payments (capitation)
- Same 65 quality metrics as the MSSP to meet the "triple aim"

** Center for Medicare and Medicaid Innovation*



Where do the Patients Come From?

- Attribution/Assignment Models
  - Patients are attributed based upon historic frequency of visits to providers
  - Patients are attributed based upon episodes of care

Patient Protections and Other Program Requirements

- CMS will publicly report the quality performance of Pioneer ACOs on its website
- Pioneer ACOs will be required to survey aligned beneficiaries on an annual basis using an amended version of the CAHPS Clinician and Group Survey
- CMS will analyze service utilization and may investigate utilization patterns through beneficiary surveys, medical records audits, or other means to ensure that Pioneer ACOs do not reduce necessary care

SOURCE: Akin Gump Strauss Hauer & Feld LLP/SNR Denton

Operational Requirements

- Robust electronic health record (EHR) and data analytic ability
  - EHR roll-outs
- Strong clinical resources
  - Care coordination & seamless transitions
  - Quality improvement
  - Population management
- Ability to engage patients and create patient-centered programs
  - "Care Navigators"
  - Health education
  - Disease management & prevention
- Partnership with community stakeholders

Physicians

- Primary Care Physicians must choose 1 ACO
  - Drives attribution
  - Potential Care Coordination Payments
- Specialists may be part of multiple ACO's

Actionable Performance Measures

- Health IT (EHR, etc)
- Shift from individual, process related measures to population based metrics with specific outcome goals
- Emphasis on:
  - Care coordination
  - Shared decision making
  - Patient experience
  - Population health
  - Evidence-based medical decision making

Proposed* Quality Domains, Sample Measures, and Data Sources**

Domain (# of measures)	Sample Measures	Data Source(s)
Patient Safety (2)	• Health Care Acquired Conditions Composite	8 measures are survey based, 11 measures require claims only, 46 require some clinical data or data from more complete EHRs
Patient/Caregiver experience (7)	• Getting timely care & appointments • Health status/ functional status	
Preventive Health (9)	• Flu immunization • Colorectal cancer screening	
Care Coordination (16)	• Risk-standardized, All condition readmission • % of all MDs meeting HITECH EHR meaningful use	
At-Risk Population/ Frail Elderly (31)	• Diabetes HcA1c Control (<8%) • Heart Failure: Weight Measurement • COPD: Spirometry Evaluation • Falls: Screening for fall risk	

*Proposed metrics to be finalized with CMS Final Rule and quality data will be publicly-reported

** ***Source: ACO Learning Network, 2011***

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Potential Payment Models

- Shared Savings
  - Not likely to be "enough", especially in mature markets
  - Good for entry level ACO's, no risk
  - Still rewards FFS approach
- Partial Capitation
  - Assures access to capital in advance
  - Resources required to be successful
- Global Capitation
  - Mature groups with experience in this arena
  - Risk

Where are Savings Going to Come From?

- Decreased inpatient bed days
- Increased generic medication usage
- Using appropriate specialists
- Appropriate place of service (Office vs. ASC Vs. Hosp) (Office/Urgent Care vs ER)
- Use Hosp A vs. Hosp B if significant cost differences and equal quality
- Patient Experience

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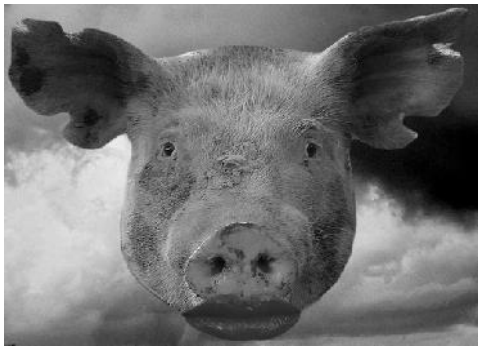
It's Not Just Dad's HMO



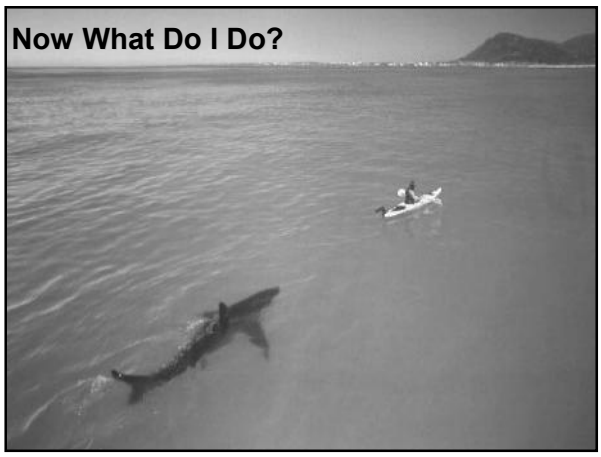
The Contrast

- **HMO**
  - Major focus on saving money
  - "Gatekeeper" concept to limit access to care
  - Little/no consumer input
  - Authorizations required
  - Narrow provider network
- **ACO**
  - Major focus on quality of care
  - "Care Coordinator" concept to facilitate access, reduce redundancy and waste
  - Emphasis on prevention and chronic disease management
  - Consumer engagement
  - Specific Quality outcomes required to achieve savings
  - No authorizations required
  - Broader physician network

Today's Reality

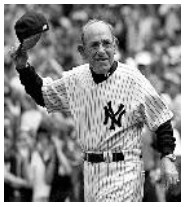
- If the ACO concept is not successful:
  - Healthcare costs will rise beyond affordability
  - Independent Review Commission 2014
  - Medicare and PPO plans will have no option but to cut rates
- ACOs offer an opportunity to address the problems proactively to improve quality and bend the cost curve

Now What Do I Do?



"When you come to the fork in the road, take it"

Yogi Berra



Tremendous Opportunity!

- This is in your wheelhouse!!
- Education
  - Patients
  - Providers
- Care Coordination
- Communication
- Point of Care Interaction

Approach

- Engage
  - Provider Organizations
  - Health Plans
  - Hospitals
  - Physicians
  - Patients
- Advocate
- Data

Today's Discussion

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Health Care Tomorrow


Thank you!