RELIANCE CONSULTING GROUP

ACCOUNTABLE CARE ORGANIZATIONS
& ORTHOPAEDIC PRACTICES:
ARE YOU READY FOR JANUARY 1, 2014?

TOS 2013 Annual Conference
September 2013

Presented by :
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RCG Managing Director

INTRODUCTION

PHYSICIANS' PRACTICE WORLD IN 2014-2016:

- The percentage of independent physicians will still be the majority (56%) compared to employed physicians (44%)
- The percentage of healthcare providers in clinical integration will more than double to 46%
- More than half (51%) of medical providers will be involved in population health management
- ACO participation among medical providers will grow from 41% to 55%
- More than half of medical providers(52%) will pursue patient-centered medical homes compared to 39% currently

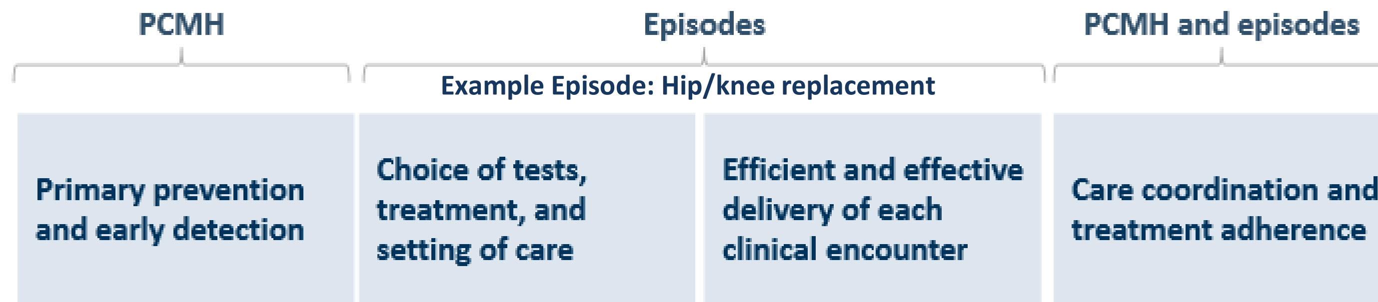
Source: HealthLeaders Media Survey, "Physician Alignment in the New Shared Risk Environment, September 2013

INTRODUCTION

Tennessee Payment Reform Initiative

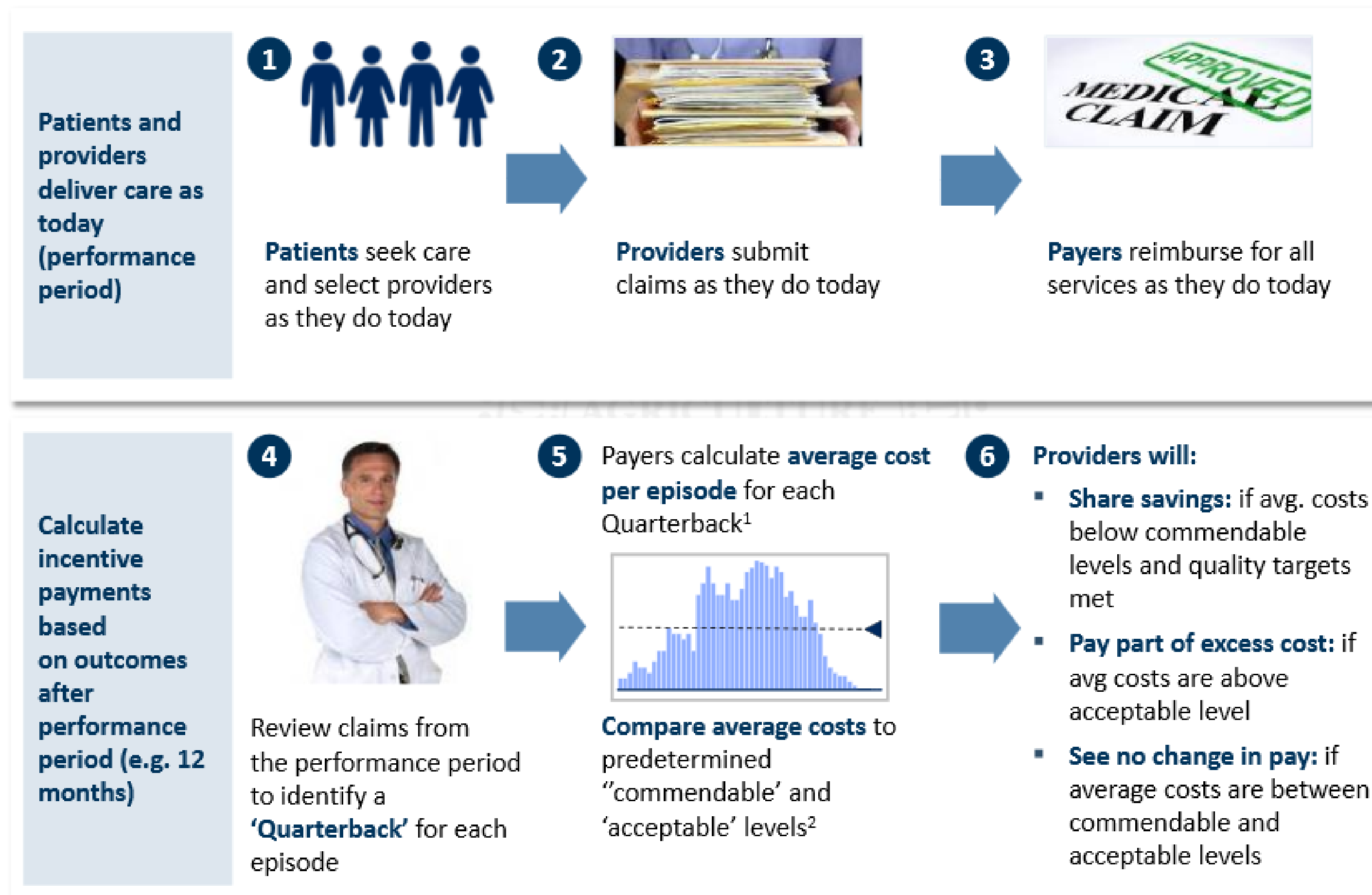
"I believe Tennessee can also be a model for what true health care reform looks like…It's my hope that we can provide quality healthcare for more Tennesseans while transforming the relationship among health care users, providers and payers. If Tennessee can do that, we all win."

-Governor Haslam's Address to a joint session of the Tennessee state Legislature, March 2013



Source: Tennessee Payment Reform Initiative, http://www.tn.gov/HCFA/forms/MayProviderMeeting.pdf, May 22, 2013

Tennessee Payment Reform Initiative

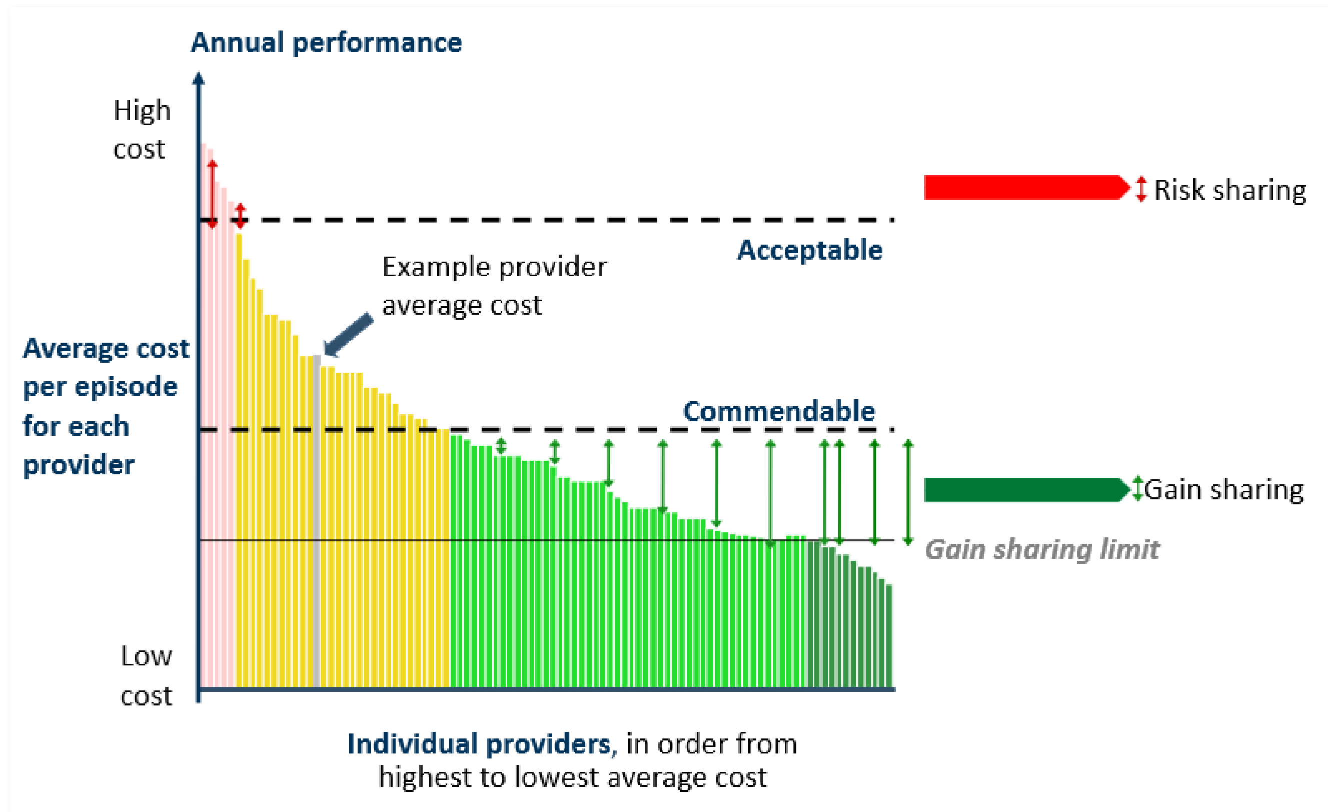


Source: Tennessee Payment Reform Initiative, http://www.tn.gov/HCFA/forms/MayProviderMeeting.pdf, May 22, 2013

Tennessee Payment Reform Initiative

Example: In implementing retrospective-based payment, savings and cost sharing with providers derives from evaluating provider performance against acceptable and commendable "thresholds"

ILLUSTRATIVE EXAMPLE



Source: Tennessee Payment Reform Initiative, http://www.tn.gov/HCFA/forms/MayProviderMeeting.pdf, May 22, 2013

AGENDA

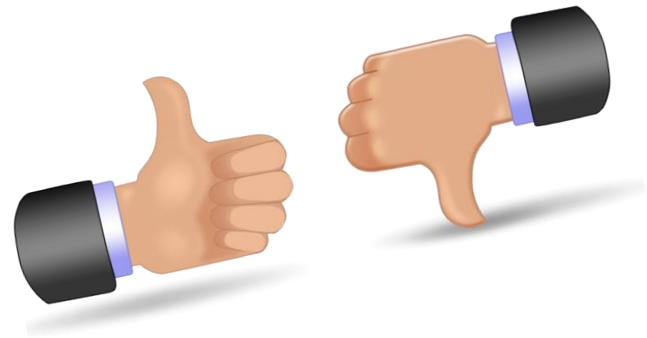
- **Introduction**
- **ACO Results: Successes & Failures**
- **ACO Infrastructure**
- **ACO Readiness Assessment**
- **Q & A**

WHAT IT TAKES TO ENTER INTO AN ACO CONTRACT…

WHAT IT TAKES TO MANAGE AN ACO CONTRACT…

ACO RESULTS: SUCCESSES & FAILURES

- **What we know about ACOs**
- **What we don't know about ACOs**
- **Pioneer ACOs: Successes & Failures**



ACO RESULTS: SUCCESSES & FAILURES

What we know about ACOs

- They are growing: 40 fold in 3 years
- They are complex: Population Health Mgt
- They are not portable: geographic differences
- They can achieve CMS' Triple Aim:
  - Lower Cost, Higher Quality, Better Health
- They require physician leadership
- They require new technologies (e.g., EMR/EHR)
- They must assess and manage both health & financial risk

What we don't know about ACOs

- Are they sustainable-only 3 years experience?
- Is there a successful business model?
- Will they replace the SGR formula?
- How much will they be monitored/audited?
- Will projected savings be realized?
- Will they lead to a "Big Three" marketplace?

ACO RESULTS: SUCCESSES & FAILURES

Pioneer ACOs: Success & Failures

Source: "Complex Coordination" & "Risk Was Too Great", Melanie Evans and Jessica Zigmond, *Modern Healthcae*, July 22, 2013

ACOs & ORTHOPAEDIC SPECIALISTS

- **How do ACOs work & Where do specialists (orthopaedic physicians) fit in?**
- **What are the PQRS reporting requirements for orthopaedic specialists?**
- **What is the criteria for choosing the right ACO?**

ACOs & ORTHOPAEDIC SPECIALISTS

ACO INFRASTRUCTURE AND FEEDBACK LOOP

PATIENT POPULATION	GOAL OF SERVICE	INTERNAL CARE TEAM	INFORMATIONAL RESOURCES	EXTERNAL CARE TEAM
Healthy Patients	Preventative Care	PCP Mid-Level provider RN LPN/MA PSR	Self Management Tool EMR IT Reports Quality Data Patient Feedback	N/A
Acute Patients	Episodic Care	PCP Mid-Level provider RN LPN/MA PSR Care Coordinator	E-Visit Feedback Medication Management EMR IT Reports Quality Data Patient Feedback	Specialists ER & Urgent Care Hospitalists Home Health Providers Social Workers Mental Health Providers Community Resources
Chronic Patients	Chronic Care	PCP Mid-Level provider RN LPN/MA PSR Care Coordinator	E-Visit Feedback Medication Management EMR IT Reports Quality Data Patient Feedback	Specialists ER & Urgent Care Hospitalists Home Health Providers Social Workers Mental Health Providers Community Resources Case Managers
End of Life Patients	Palliative Care	PCP Mid-Level provider RN LPN/MA Caregiver Care Coordinator	E-Visit Feedback Medication Management EMR IT Reports Quality Data Patient Feedback	Specialists Home Health Providers Social Workers Mental Health Providers Community Resources

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ACOs & ORTHOPAEDIC SPECIALISTS

2013 PQRS Measures List: Orthopaedic Reporting Measures

NQF #	PQRS #	National Quality Strategy Domain	Measure Description[a]	Measure Developer	Reporting Options
0270	20	Patient Safety	**Perioperative Care: Timing of Prophylactic Parenteral Antibiotic – Ordering Physician:** Percentage of surgical patients aged 18 years and older undergoing procedures with the indications for prophylactic parenteral antibiotics, who have an order for prophylactic parenteral antibiotic to be given within one hour (if fluoroquinolone or vancomycin, two hours), prior to the surgical incision (or start of procedure when no incision is required)	* AMA-PCPI/NCQA	Claims, Registry, Periop Measures Group (C/R)
0268	21	Patient Safety	**Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second Generation Cephalosporin:** Percentage of surgical patients aged 18 years and older undergoing procedures with the indications for a first OR second generation cephalosporin prophylactic antibiotic, who had an order for cefazolin OR cefuroxime for antimicrobial prophylaxis	* AMA-PCPI/NCQA	Claims, Registry, Periop Measures Group (C/R)
0271	22	Patient Safety	**Perioperative Care: Discontinuation of Prophylactic Parenteral Antibiotics (Non-Cardiac Procedures):** Percentage of non-cardiac surgical patients aged 18 years and older undergoing procedures with the indications for prophylactic parenteral antibiotics AND who received a prophylactic parenteral antibiotic, who have an order for discontinuation of prophylactic parenteral antibiotics within 24 hours of surgical end time	* AMA-PCPI/NCQA	Claims, Registry, Periop Measures Group (C/R)
0239	23	Patient Safety	**Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients):** Percentage of surgical patients aged 18 years and older undergoing procedures for which VTE prophylaxis is indicated in all patients, who had an order for Low Molecular Weight Heparin (LMWH), Low-Dose Unfractionated Heparin (LDUH), adjusted-dose warfarin, fondaparinux or mechanical prophylaxis to be given within 24 hours prior to incision time or within 24 hours after surgery end time	* AMA-PCPI/NCQA	Claims, Registry, Periop Measures Group (C/R)

Source: www.CMS.gov 2013

The 6 criteria for choosing the right ACO:

1. The physician should only be accountable for what is under his or her control
2. The model should be patient-centered
3. It should also be physician-friendly
4. The plan should have a truly interoperable EMR with clinical decision support
5. There should be specific metrics for what constitutes "cost reduction"
6. Have your attorneys review the contract extremely well and with a skeptical eye

Source: HCPro Managed Care Contracting & Reimbursement Advisor, "Choosing the Right ACO For You", October, 2013

ACO READINESS ASSESSMENT

ACO READINESS ASSESSMENT

CRITIERIA	Development Required	Limited Capabilities	In-Place: Performance Evident
Governance/Leadership			
• Stakeholders are committed to Triple Aim mission			
• Inter-organizational representation in governance			
• Capital and personnel resources necessary for mission			
• Legal entity that meets ACO requirements			
• Engaged physician leadership & ongoing education			
Organizational Culture			
• Infrastructure supports patient population management			
• Collaboration tools and reports to support providers			
• Monitoring of patient-centric needs & solutions			
• Physician led provider teams at treatment sites			
Relationships with other Providers			
• Sufficient patient access to PCMH providers			
• Dedicated primary care sufficient for population			
• Specialist protocols supporting best practices			
• Inter-provider communication processes & agreements			
IT Infrastructure			
• EMR/EHR & Practice Management Systems in place			
• Electronic data capture & care management reporting systems			
• IT workforce with ongoing skill development programs			
• Meaningful use of IT systems			

ACO READINESS ASSESSMENT

CRITIERIA	Development Required	Limited Capabilities	In-Place: Performance Evident
Clinical Management Infrastructure			
• Clinical quality outcomes & reporting capabilities			
• Evidence-based standards of care employed			
• Multi-level care management programs & staff			
• Clinical pathways for best practices monitoring			
Financial Risk Management			
• Medical service expense (MSE) management capabilities			
• Processes to assess financial risk of VBP models			
• Cost accounting capabilities across episodes			
• Provider-health plan partnerships			
Ability to Receive & Distribute Risk Payments			
• Knowledge about quality incentive payment models			
• Multi-provider agreements to distribute payments			
• Access to actuarial support for payment distributions			
• Financial reporting systems specific to risk payments			
Patient Engagement & Satisfaction			
• Care management results available to patients			
• Commitment to respect patient rights			
• Method for patients to submit & receive feedback			
• Wellness activities & community services for patients			

NOW WHAT???

The road to value based payment…

begins with payer contracting

Q & A

ACCOUNTABLE CARE ORGANIZATIONS

& ORTHOPAEDIC PRACTICES:

ARE YOU READY FOR JANUARY 1, 2014?

For more information about Accountable Care Organizations (ACOs), visit Reliance Consulting Group at:
www.RelianceCG.com and click on the **'ACO Toolkit'** tab
Or
Contact Dr. Schmitt directly: **jschmitt@reliancecg.com**