ACCOUNTABLE CARE ORGANIZATIONS:
GETTING READY FOR ACO PARTICIPATION

Presented by:
John P. Schmitt, Ph.D.
RCG Managing Director

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8-23-13
“The healthcare policy world has crackled with high-level debate over ACOs in the past several years…But the types of ACO models being tried today are so varied and complex that it’s difficult to draw conclusions about their ultimate success. Despite the unanswered questions, providers are pumping massive investments into ACOs across the nation.”

-Joe Carlson, “Although patients may not know it, ACO’s are increasingly on their team, aiming to provide better care at lower costs”
Modern Healthcare, April 1, 2013
REDESIGNING CARE MODELS

Q | Which of the following initiatives is your organization likely to be pursuing within three years?

Integrated delivery system | 51%
Collaborative care: patient-centered medical home | 48%
Collaborative care: ACO | 48%
Hospital-physician shared savings agreements | 36%
Population health model | 35%
Involve independent physicians in decision-making | 29%
Payer-provider shared risk agreements | 28%
Other collaborative care | 26%
Employer-provider shared risk agreements | 19%
Employer-payer shared risk agreements | 8%

Base = 279  Multi response

AGENDA

• Introduction
• ACO Results: Successes & Failures
• ACO Airlines Analogy
• ACO Readiness Assessment
• ACOs vs HIXs
• Q & A
WHAT IT TAKES TO ENTER INTO AN ACO CONTRACT...
WHAT IT TAKES TO MANAGE AN ACO CONTRACT...
ACO RESULTS: SUCCESSES & FAILURES

• 2013 ACO Survey Results
• What we know about ACOs
• What we don’t know about ACOs
• Pioneer ACOs: Successes & Failures
2013 ACO Survey Results

ACO Structure

What’s included in the ACO?
- Hospital systems: Yes 64.9%, No 35.1%
- Physician groups: Yes 91.9%, No 8.1%
- Insurers: Yes 91.9%, No 8.1%

Type of ownership
- Not-for-profit: 32.4%
- Privately held, for-profit: 27%
- Taxable not-for-profit: 5.5%
- Limited liability company: 13.5%
- Other*: 21.6%

*Includes nonreporting entities and not-for-profit/for-profit partnerships

Marketplace Measurements

ACO at risk for financial loss?
- Yes 37.8%, No 62.2%

Using measure of care coordination?
- Yes 83.8%, No 16.2%

Organization profitability
- Profitable 39.3%
- Break-even 42.9%
- Unprofitable 17.9%

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
• They require physician leadership
• They require new technologies
• They must assess and manage health risks
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 the savings predicted be realized?
- Will they lead to a “Big Three” marketplace?
Pioneer ACOs: Success & Failures

Source: “Complex Coordination” & “Risk Was Too Great”, Melanie Evans and Jessica Zigmond, Modern Healthcare, July 22, 2013
Pioneer ACOs: Eight Success Factors

1. Must understand risk formulas and target utilization requirements to achieve savings;
2. Quickly assess attributed population health needs & develop protocols to meet needs;
3. Use analytic tools to accurately track and report quality measures and produce actionable data;
4. Engage patients and care givers in the care delivery process;
Pioneer ACOs: Eight Success Factors

5. Construct an effective care management team and communication system to produce necessary & appropriate care interventions;

6. Use technology resources to enable intra & inter-provider communication;

7. Develop a patient-centric culture led by physicians that permeates entire ACO staff;

8. Craft a 3 to 5 year Business Plan as a guide for ACO success-and stick to it.
Welcome to ACO Airlines

ACO Growth - Lift Off

Payment Models - Refueling

Attributes - Flight Design

Infrastructure - Instruments & Flight Control
“In this country, we’ve been flying the Healthcare Airlines with planes that have no instruments, no gas gauge, no flight attendants, and we don’t know where we’re going or what we’re doing. And until we have transparency of results and share best practices among organizations to make all healthcare systems better, that’s what we’ll continue to fly.”

-James Weinstein, DO, MS, President and CEO of Dartmouth-Hitchcock Health System
Transitioning to ACO Airlines…
ACO Growth (lift off):

- 2.4 million Medicare patients receive care through ACOs recognized by CMS (Centers for Medicare & Medicaid Services)
- 15 million non-Medicare patients get services from practices with CMS ACO status
- 8 million to 14 million patients are in ACOs run by commercial insurers
- 328 ACOs are reported as of December, 2012 up from 164 counted in September 2011-a 100% increase over the last year
- CMS contracted with more than 250 ACOs between 2011-2013 and is expected to add 100-200 more by 2015.

Source: Sources: “ACOs already surging, poised for even more growth” amednews.com, 12/10/12; ACOs: “The Least Agreed Upon Concept in Healthcare?”, Becker’s Hospital Review, 6/10/13
ACO Payment Modeling (Refueling):

The American Academy of Actuaries broke down five popular ACO payment models in a recent report (listed from lowest to highest level of risk):

1. **“One-sided” shared savings**—providers share in a portion of the savings they achieve in a modified fee-for-service model. There is only upside risk—no financial loss sharing.

2. **“Two-sided” shared savings**—providers take on downside and upside risk in a fee-for-service based payment model.

3. **Bundled/Episode payments**—providers receive a single payment for all of one patient’s services for one episode of care…They take on the financial risk if the cost of treating an episode of care exceeds the payment.
4. **Partial capitation/global payments** - providers may be at risk for some or all of physicians services…but not for hospital or other non-physician services

5. **Global payments** - providers receive monthly or annual payments, regardless of the care services they performed in that time period…The only way for a provider to increase its financial benefit is to increase efficiency and reduce costs

Source: “5 Payment Models for ACO Providers”, Heather Punke, Becker's Hospital Review, 12/28/12
(Flight Design) The Commonwealth Fund and the Institute of Medicine have identified 11 attributes of a payment system that would be superior to the current delivery system:

1. Care would be patient-centered
2. Care would be safe and effective
3. Care would be timely and accessible
4. Care would be efficient with little waste
5. Care would be coordinated among providers and across facilities
6. Continuity of care and care relationships would be facilitated
7. Collaboration among providers would deliver high quality, low cost care
8. Patient’s clinical information would be efficiently exchanged
9. Caregivers would engage patients in ways that would maximize health
10. Accountability for each aspect and for total care would be clear
11. Continuous innovation, learning and improvement would occur

Source: Kent Bottles, MD, medpagetoday’s KevinMD, Jan. 3, 2013
## ACO INFRASTRUCTURE FOR POPULATION HEALTH MANAGEMENT (instrument panel)

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

<table>
<thead>
<tr>
<th>CRITERIA</th>
<th>Development Required</th>
<th>Limited Capabilities</th>
<th>In-Place: Performance Evident</th>
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<tbody>
<tr>
<td><strong>Governance/Leadership</strong></td>
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<tr>
<td>• Stakeholders are committed to Triple Aim mission</td>
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<td>• Inter-organizational representation in governance</td>
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<tr>
<td>• Capital and personnel resources necessary for mission</td>
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<tr>
<td>• Legal entity that meets ACO requirements</td>
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<td>• Engaged physician leadership &amp; ongoing education</td>
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<td><strong>Organizational Culture</strong></td>
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<tr>
<td>• Infrastructure supports patient population management</td>
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<td>• Collaboration tools and reports to support providers</td>
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<tr>
<td>• Monitoring of patient-centric needs &amp; solutions</td>
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<tr>
<td>• Physician led provider teams at treatment sites</td>
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<td><strong>Relationships with other Providers</strong></td>
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<tr>
<td>• Sufficient patient access to PCMH providers</td>
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<tr>
<td>• Dedicated primary care sufficient for population</td>
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<td>• Specialist protocols supporting best practices</td>
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<tr>
<td>• Inter-provider communication processes &amp; agreements</td>
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<tr>
<td><strong>IT Infrastructure</strong></td>
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<tr>
<td>• EMR/EHR &amp; Practice Management Systems in place</td>
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<td>• Electronic data capture &amp; care management reporting systems</td>
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<td>• IT workforce with ongoing skill development programs</td>
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<td>• Meaningful use of IT systems</td>
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<td>CRITERIA</td>
<td>Development Required</td>
<td>Limited Capabilities</td>
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<tr>
<td>Clinical Management Infrastructure</td>
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<td>• Clinical quality outcomes &amp; reporting capabilities</td>
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<td>• Evidence-based standards of care employed</td>
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<td>• Multi-level care management programs &amp; staff</td>
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<td>• Clinical pathways for best practices monitoring</td>
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<td>Financial Risk Management</td>
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<td>• Medical service expense (MSE) management capabilities</td>
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<td>• Processes to assess financial risk of VBP models</td>
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<td>• Cost accounting capabilities across episodes</td>
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<td>• Provider-health plan partnerships</td>
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<td>Ability to Receive &amp; Distribute Risk Payments</td>
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<td>• Knowledge about quality incentive payment models</td>
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<td>• Multi-provider agreements to distribute payments</td>
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<td>• Access to actuarial support for payment distributions</td>
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<tr>
<td>• Financial reporting systems specific to risk payments</td>
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<tr>
<td>Patient Engagement &amp; Satisfaction</td>
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<tr>
<td>• Care management results available to patients</td>
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<tr>
<td>• Commitment to respect patient rights</td>
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<tr>
<td>• Method for patients to submit &amp; receive feedback</td>
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<tr>
<td>• Wellness activities &amp; community services for patients</td>
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Next Session: filling the seats through ACO Payer Contracting
ACOs vs HIXs

What We Know About Health Insurance Exchanges (HIXs)

1. HIXs are on-line marketplaces for consumers (some of whom will receive subsidies) to shop for cost competitive coverage;
2. The HIXs will be launched in every state 10/1/13 with coverage starting 1/1/14;
3. There are still significant technical and administrative issues (e.g. 4 benefit plan levels) to be worked out;
4. “Navigators” will guide consumers through the process of buying coverage on the HIX;
5. In some states Medicaid managed-care insurers will offer HIX coverage;
6. “Narrow Networks” membership will be offered to providers in exchange for reduced rates;
7. Some commercial payers are extending HIX participation to physicians simply as contract amendments—some aren’t;
8. The bottom line is—if HIX premiums are going to be lower than standard commercial premiums, then payments to providers (e.g. 85% of premiums) must be lower.
# ACO vs HIX Comparison Matrix

<table>
<thead>
<tr>
<th>Feature</th>
<th>ACO</th>
<th>HIX</th>
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</thead>
<tbody>
<tr>
<td>Purpose</td>
<td>Accountable care delivery model</td>
<td>On-line health insurance marketplace</td>
</tr>
<tr>
<td>Mission</td>
<td>Triple Aim: better population health, lower cost, higher quality</td>
<td>Low Premiums, competitive marketing, equivalent quality</td>
</tr>
<tr>
<td>Revenues</td>
<td>Received from payers for care delivery, good quality, and resultant savings</td>
<td>Federal Planning Grants awarded under PPACA or premium fees</td>
</tr>
<tr>
<td>Expenses</td>
<td>Medical service delivery costs, ACO administration, IT, and care management</td>
<td>Marketing expenses, IT, HIX Administration e.g. “Navigators” and regulatory costs</td>
</tr>
<tr>
<td>Provider’s Role</td>
<td>Join provider care team, comply with protocols, participate in shared savings/risks</td>
<td>Contract with health plans offering HIX products usually through narrow networks</td>
</tr>
</tbody>
</table>
ACOs vs HIXs

Frequently Asked Questions About Ohio HIX:

http://www.insurance.ohio.gov/Consumer/Pages/FederalHealthReformFAQs.aspx
SUMMARY

• ACO Results: Successes & Failures
• ACO Airlines Analogy
• ACO Readiness Assessment
• ACOs vs HIXs
• Assess internal capabilities & resources
  • Time availability
  • Internal expertise
  • Analytic tools & resources
  • ACO Readiness Assessment results

• Determine what should be outsourced
  • Readiness criteria development
  • Strategic payer negotiations
  • Payer relationship evaluations
  • Contracting priorities and strategies
Q & A
ACCOUNTABLE CARE ORGANIZATIONS:
GETTING READY FOR ACO PARTICIPATION

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